# Draft California Strategic Plan on Suicide Prevention: Every Californian Is Part of the Solution

Based on Recommendations of the
Suicide Prevention Plan Advisory Committee

California Department of Mental Health
**DRAFT**
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## Acknowledgements

In September 2006, Governor Arnold Schwarzenegger directed the California Department of Mental Health (DMH), through a veto message to Senate Bill 1356 (Lowenthal), to administratively develop a statewide strategic plan on suicide prevention. The DMH and the Health and Human Services Agency were to build on work done by the California Suicide Prevention Advocacy Network and coordinate with all interested constituency groups and state and local agencies to develop the plan by May 1, 2008. The Department convened the Suicide Prevention Plan Advisory Committee, listed below, to provide recommendations for the plan.

The Advisory Committee met over approximately nine months to craft the strategic directions and recommended actions contained in this document. In addition to the committee meetings, two stakeholder workshops were held in September 2007, to ask the public, including youth, families, and survivors of suicide attempts, to provide input on the draft plan's preliminary recommendations.

We deeply appreciate the Committee's hard work and acknowledge the personal commitment and many contributions of the individuals listed below.

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# Introduction

The statistics about suicide are alarming. Suicide is the tenth leading cause of death in California. Every year approximately 3,300 Californians lose their lives to suicide; more suicide deaths are reported in our state than deaths caused by homicides. On average, nine Californians die by suicide every day. Suicide and suicidal behaviors occur among all age groups and across all socioeconomic, racial, and ethnic backgrounds.

The causes of suicide are complex and include an array of biological, psychological, social, environmental, and cultural risk factors. Too often there is lack of coordination between service systems and providers and a lack of knowledge about how to recognize the warning signs of suicide. And for far too long, suicide has been viewed as a taboo subject. Fear of stigma and discrimination surrounding suicide can be so pervasive that it often deters people from seeking help.

Suicide is a devastating tragedy in terms of the lives lost and the emotional heartbreak family members and other loved ones endure. This tragedy is even more distressing because these suicide deaths are preventable.

Traditionally, suicide has been considered primarily a concern of the mental health system, largely due to the connection between mental illnesses, such as depression, and the elevated risk of suicide. However, in 2001, the President's New Freedom Commission called for a change that would place mental health into the context of the broader public health system. The transformed system would provide quality care for those in need, but it would also promote resiliency, recovery, and health.

In response to this change and in combination with other events, Governor Arnold Schwarzenegger in 2006 charged the California Department of Mental Health with the development of the *California Strategic Plan on Suicide Prevention*. The Department of Mental Health embarked upon this work in partnership with the Suicide Prevention Plan Advisory Committee composed of mental health experts, advocates, providers, researchers, and representatives from various non-profit and government agencies. The Advisory Committee also included other important voices—survivors of suicide attempts and suicide loss.

The *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution* is built upon the vision that a full range of strategies, starting from prevention and early intervention, should be targeted to Californians of all ages, from children and youth to adults and older adults. To effectively reduce suicides and suicidal behavior, communities need prevention services to promote health

and address problems long before they become acute as well as a coordinated system of services to effectively respond to crisis situations.

This *California Strategic Plan on Suicide Prevention* (Plan) serves as a blueprint for action at the local and state levels. The Plan is intended to guide the work of policy makers, program managers, providers, funders, and others in bringing systems together to better coordinate their efforts and to enhance needed prevention, intervention, and postvention[1] services. The plan consists of four major parts.

- Part I presents information about suicide's impact and magnitude from different sources and different perspectives.
- Part 2 describes successful and promising strategies, practices, and polices that have been used to prevent suicide.
- Part 3 provides the Advisory Committee's recommended actions to reduce suicide deaths and the incidence of suicidal behaviors in California. Many of the recommendations require a long-term effort; others can be implemented immediately.
- Finally, Part 4 lists the next steps for local and state action.

This Plan should be viewed as a dynamic document that will be periodically reviewed and revised to reflect evolving needs in California. Over time, it is anticipated that the full spectrum of strategies from prevention through intervention will be more comprehensively addressed.

Suicide prevention must be a priority in our state. While many challenges lie ahead in carrying out this work, tremendous opportunities also exist. With thousands of lives at stake each year, every Californian needs to be part of the solution.

[1] A postvention is an intervention conducted after a suicide or attempted suicide, consisting of follow-up care and/or support for the bereaved (family, friends, professionals and peers).

# California Strategic Plan on Suicide Prevention: Every Californian Is Part of the Solution

## OVERVIEW OF CORE PRINCIPLES, STRATEGIC DIRECTIONS, RECOMMENDED ACTIONS, AND NEXT STEPS

The following table provides a brief summary of core principles, strategic directions, recommendations, and next steps detailed in Parts 3 and 4 of the Plan. The six core principles are embedded in all levels of planning, service delivery, and evaluation across the four strategic directions. Strategic directions are broad levels of focus that the more specific recommended actions and next steps address. The recommended actions are not an exhaustive list, but they reflect critical priorities to reduce suicide and its tragic consequences. Finally, the Next Steps outline activities that should be taken at the state and local levels to begin the first implementation phase of the Plan.

**Core Principles**

- Implement **culturally competent** strategies and programs that **reduce disparities**.
- **Eliminate barriers** and **increase outreach and access** to services.
- **Meaningfully involve survivors** of suicide attempts and the family members, friends, and caregivers of those who have completed or attempted suicide, and representatives of target populations.
- Use **evidence-based models** to strengthen program effectiveness and build upon existing **promising practices.**
- **Broaden the spectrum of partners** involved in a comprehensive system of suicide prevention.
- Employ a **life span approach** to suicide prevention.

**Strategic Direction 1: Create a System of Suicide Prevention**

Increase collaboration among state and local agencies, private organizations and communities by coordinating and improving suicide prevention activities and services throughout the state, from health and mental health promotion through crisis intervention.

**RECOMMENDED ACTIONS – STATE**

1.1 Establish a statewide Office of Suicide Prevention (OSP).

1.2 Engage a coalition of public partners to integrate, coordinate, enhance and improve policies and practices.

1.3 Develop a network of statewide public and private organizations.

1.4 Convene and facilitate working groups that will address specific populations and issues.

1.5 Expand the number and capacity of accredited suicide prevention hotlines based in California.

1.6 Create a statewide consortium of suicide prevention hotlines.

1.7 Identify and implement needed improvements in confidentiality laws and practices.

**NEXT STEPS – STATE**

1.A Staff the Office of Suicide Prevention established on February 6, 2008.

1.B Issue an action plan that assesses the current level of activities and major gaps, and identifies objectives toward implementing the initial activities described in "Next Steps".

1.C Establish a technical assistance infrastructure to support local suicide prevention efforts.

1D. Establish a coalition of state-level organizations to coordinate suicide prevention efforts. The coalition should include:

- K-12 and higher education
- Services for older adults
- Criminal and juvenile justice systems
- Veterans services
- Health and mental health services.

1.E Assess the current status of suicide prevention hotlines in California and build a consortium of accredited suicide prevention hotlines statewide.

1.F Support expanded functions for the accredited suicide prevention hotline centers such as training centers and after-care services.

1.G Enhance the database for monitoring, tracking, evaluating, and reporting suicide prevention hotline calls in California.

1.H Provide technical assistance to expand or link accredited hotlines to additional venues and formats to improve access to information on local services.

1.I Provide technical support to counties to conduct a comprehensive assessment of suicide prevention services.

1.J Link and provide technical support to county-level advisory councils.

**Strategic Direction 1: Create a System of Suicide Prevention**

Increase collaboration among state and local agencies, private organizations and communities by coordinating and improving suicide prevention activities and services throughout the state, from health and mental health promotion through crisis intervention.

**RECOMMENDED ACTIONS – LOCAL**

1.8 Appoint a county liaison to the state Office of Suicide Prevention, and convene a suicide prevention advisory council.

1.9 Develop a local suicide prevention action plan.

1.10 Enhance links between systems and programs to better address gaps in services and identify resources.

1.11 Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging, social services, first responders, and hotlines.

1.12 Integrate suicide prevention programs into education institutions, services for older adults, the workplace, and the criminal and juvenile justice systems.

1.13 Develop and promote programs that reduce or eliminate gaps for historically underserved racial and ethnic groups and other high-risk populations.

1.14 Ensure that the county has access to at least one accredited suicide prevention hotline call center.

1.15 Explore opportunities for training and consultation between counties to develop suicide prevention hotline capacity.



**NEXT STEPS – LOCAL**

1.K Appoint a liaison to the state Office of Suicide Prevention in each county.

1.L Convene or build upon an existing entity to establish a local suicide prevention advisory council to develop a suicide prevention system.

1.M Design and implement a comprehensive assessment of the existing county suicide prevention services and supports and the major gaps that will inform the development of a local suicide prevention action plan.

1.N Develop a local suicide prevention action plan through an inclusive community process.

1.O Assess capacity of local or regional accredited suicide prevention hotline(s) and take steps needed to achieve accreditation of call centers or build the capacity of already accredited call centers.

**Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide**

Develop and implement service and training guidelines to promote effective and consistent suicide prevention, early identification, referral, intervention, and follow-up care across all service providers.

**RECOMMENDED ACTIONS – STATE**

2.1 Convene expert workgroups to establish suicide prevention service and training guidelines and model curricula for targeted service providers.

2.2 Expand opportunities for training for selected occupations and facilities.

2.3 Determine which occupations are to be targeted for required training and how the requirements will be implemented.

**NEXT STEPS – STATE**

2.A Assess the current criteria and standards for service and training guidelines that address suicide prevention, early intervention, treatment, and suicide attempt follow-up care for California's diverse population.

2.B Recommend, develop, and broadly promote standard service and training guidelines and curricula for targeted service providers. Review licensing and credentialing processes to assess viability of new training requirements.

2.C Coordinate and review surveys on local training needs and provide support to counties to address their local needs.

2.D Deliver "train the trainer" sessions for targeted service providers.

**RECOMMENDED ACTIONS – LOCAL**

2.4 Establish annual targets for suicide prevention training and develop and implement a plan to meet these targets.

2.5 Increase the priority of suicide prevention training and tailor and enhance state guidelines to meet local needs

**NEXT STEPS – LOCAL**

2.E Review local Mental Health Services Act Workforce Education and Training component assessments to expand suicide prevention training. If needed, conduct a supplemental survey for suicide prevention training and technical assistance needs. Set local training targets for selected occupations and develop a plan to meet those targets and a process to measure progress.

2.F Tailor, disseminate, and promote service and training guidelines. Design and implement an inclusive community process to adapt guidelines as necessary

**Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide**

Raise awareness that suicide is preventable and create an environment that supports suicide prevention and help-seeking behaviors.

**RECOMMENDED ACTIONS – STATE**

3.1 Launch and sustain a suicide prevention education campaign.

3.2 Coordinate the suicide prevention campaign with any existing social marketing campaign designed to eliminate mental health stigma and discrimination.

3.3 Engage and educate the news media and the entertainment industry.

3.4 Promote information and resources to reduce access to lethal means.

3.5 Disseminate and promote models for suicide prevention education for community gatekeepers.

**NEXT STEPS – STATE**

3.A In conjunction with any existing social marketing efforts, develop and implement an age-appropriate, multi-language education campaign to positively influence help-seeking behaviors and reduce suicidal behaviors.

3.B Obtain the necessary social marketing consultation to design, test, and promote the suicide prevention messages in ways that will benefit target populations at risk for suicide.

3.C Support local efforts to engage and educate the media by disseminating resources from national suicide prevention organizations.

3.D Identify a strategy for reducing access to lethal means in California.

3.E Identify and disseminate models that counties can use to implement suicide prevention gatekeeper education.

3.F Conduct regional training to build local capacity for peer support programs.

3.G Design and maintain a webpage for the Office of Suicide Prevention that provides links to information and identify and develop new information as needed.

**Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide**

Raise awareness that suicide is preventable and create an environment that supports suicide prevention and help-seeking behaviors.

**RECOMMENDED ACTIONS – LOCAL**

3.6 Build grassroots outreach and engagement efforts to tailor the suicide prevention campaign and activities to best meet community needs.

3.7 Engage and educate local media to promote greater understanding of the risks and protective factors related to suicide and how to get help.

3.8 Educate individuals impacted by suicide to recognize, appropriately respond to, and refer people demonstrating acute risk factors.

3.9 Promote and provide suicide prevention education for community gatekeepers.

3.10 Develop and disseminate directory information on local suicide prevention and intervention services.

3.11 Incorporate peer support and peer-operated services models.



**NEXT STEPS – LOCAL**

3.H Coordinate local outreach, awareness, and education activities with other social marketing efforts to expand suicide prevention messages and information in multiple languages.

3.I Design and implement a strategy to better engage and educate the local media on the importance of appropriate and responsible reporting of suicide deaths and information.

3.J Design a community education plan that may include:

- A community calendar of activities promoting suicide prevention
- Identifying opportunities to integrate suicide prevention information in ongoing services and programs
- Localizing national and state suicide prevention events

3.K Reach out to community gatekeepers to increase their awareness and participation in suicide prevention efforts.

3.L Develop and widely disseminate a directory of local suicide prevention services and supports and update as necessary.

3.M Foster the development of peer support programs.

**Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability**

Improve data collection, surveillance, and program evaluation and launch a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations.

**RECOMMENDED ACTIONS – STATE**

4.1 Develop a California surveillance and research agenda.

4.2 Test and adapt evidence-based practices and promote the evaluation of promising community models.

4.3 Identify or develop methodologies for evaluating suicide prevention interventions.

4.4 Make suicide data and suicide attempt data easily accessible to the public and policy makers in user friendly formats.



**NEXT STEPS – STATE**

4.A Working collaboratively with local, state, and national entities, develop a California-specific research agenda. Design a process to identify priority activities from a comprehensive review of multiple data sources and an inclusive decision-making process.

4.B Improve the data collection and reporting as well as the systems for surveillance to better understand suicide trends and rates and the impact of protective and risk factors in diverse populations. Target research activities in key areas, such as policies and programs appropriate for specific ethnic, cultural, and age groups that are gender-specific, that address trauma, and that have effective application in multiple settings.

4.C Develop an evaluation component to track and monitor the statewide effort.

4.D Develop and disseminate data reports on special topics and specific target populations to enhance programs and service delivery.

**Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability**

Improve data collection, surveillance, and program evaluation and launch a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations.

**RECOMMENDED ACTIONS – LOCAL**

4.5 Increase local capacity for data collection, reporting, surveillance, and dissemination.

4.6 Build local capacity to evaluate suicide prevention programs to improve those programs.

4.7 Establish or enhance capacity for suicide death reviews and provide regular reports to the Office of Suicide Prevention and the local suicide prevention advisory council.

4.8 Enhance reporting systems to improve the consistency and accuracy of data about suicide deaths.



**NEXT STEPS – LOCAL**

4.E Assess local data sources and reporting processes pertinent for suicide prevention and develop and implement a strategy to enhance data collection across systems.

4.F Coordinate with the state Office of Suicide Prevention to build local capacity for program evaluation.

4.G Establish a suicide death review process and provide regular reports to the suicide prevention advisory council.

## Part 1: The Problem and the Challenge

Suicide is defined as the intentional taking of one's own life[2]. It is the "final and most severe endpoint" along a continuum of self-harming behaviors (Muehlenkamp and Gutierrez, 2007). The broader term of suicidal behavior also includes self-inflicted, potentially injurious behaviors (Silverman et al, 2007). Clearly, it is important to monitor the whole range of self-harmful or injurious behaviors because they may indicate an increased risk of suicide in the future. Suicides may be "hidden" from vital statistics data; they may include a lethal overdose of prescription or illegal drugs, single car collisions with a fixed object, or incidents when an individual engages in a life-threatening behavior to the degree that it compels a police officer to respond with deadly force.

### What Causes Suicide?

The causes of suicide are complex and vary among individuals and across age, cultural, racial, and ethnic groups. The risk of suicide is influenced by an array of biological, psychological, social, environmental, and cultural risk factors (Table 1).

**Table 1: Risk Factors for Suicide** (Suicide Prevention Resource Center)

| **Bio-psycho-social Risk Factors** |
|---|
| • Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders<br>• Alcohol and other substance abuse disorders<br>• Hopelessness<br>• Impulsive and/or aggressive tendencies<br>• History of trauma or abuse<br>• Some major physical illnesses<br>• Previous suicide attempt<br>• Family history of suicide |
| **Environmental Risk Factors** |
| • Job or financial loss<br>• Relationship or social loss<br>• Easy access to lethal means<br>• Local clusters of suicides that have a contagion influence |
| **Socio-cultural Risk Factors** |
| • Lack of social support and sense of isolation<br>• Stigma associated with help-seeking behavior<br>• Barriers to accessing health and mental health services and substance abuse treatment<br>• Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution to a personal dilemma)<br>• Exposure to, including through the media, and influence of others who have died by suicide |

[2] Assisted suicide is beyond the scope of this Plan.

Many people who attempted or completed suicide had one or more warning signs before their death (Table 2). While warning signs refer to more immediate signs or symptoms in an individual, risk factors for suicide are generally longer-term factors that are associated with a higher prevalence of suicide in the population (Rudd et al., 2006). Recognition of warning signs has a greater potential for immediate prevention and intervention when those who are in a position to help know how to appropriately respond.

**Table 2: Warning Signs of Suicide** (Suicide Prevention Resource Center)

*Signs of acute suicidal ideation*:

- Threatening to hurt or kill themselves
- Looking for ways to kill themselves, e.g., seeking access to pills, weapons, or other means
- Talking or writing about death, dying, or suicide if this is unusual for the person

*Additional warning signs:*

- Expressing feelings of hopelessness
- Showing rage or anger or seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Indicating a feeling of being trapped – like there is no way out
- Increasing use of alcohol or drugs
- Withdrawing from friends, family, or society
- Experiencing anxiety, agitation, inability to sleep, or sleeping all the time
- Showing dramatic changes in mood
- Expressing no reason for living, or no sense of purpose in life

Many of those who died by suicide were described by family or friends as being depressed or having problems with a current or former intimate partner. Feelings of hopelessness and an inability to make positive changes in one's life are two consistent psychological precursors to suicidal behaviors (Gray and Otto, 2001; Evans et. al., 2005).

Trauma has a significant impact on suicide risk across the life span. A survey of over 17,000 patients at a health clinic in San Diego found that a history of adverse childhood experiences was associated with a significant increase in the prevalence of attempted suicides (Dube et al., 2001). For example, individuals reporting that their parents had separated or divorced were twice as likely to have attempted suicide, and those who were emotionally abused as children were five times as likely to have attempted suicide. For each additional adverse experience the risk of attempted suicide increased by about 60 percent. This study also found a high prevalence of depression and substance abuse among

those who did not attempt suicide, suggesting that a history of adverse childhood experiences are associated with a host of negative outcomes (Dube et al., 2001).

### What Are the Protective Factors Against Suicide?

Protective factors can reduce the likelihood of suicide by counterbalancing some of the risk factors (Table 3).

**Table 3: Protective Factors Against Suicide (DHHS, 2001)**

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for seeking help
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Examining populations with lower suicide rates can help understand potential protective factors and focuses for prevention strategies. Social (including religious), political, and economic factors may help explain different rates of suicide between countries (Goldsmith et. al., 2002). According to the World Health Organization, the highest suicide rate in the world is in Hungary (66.0) and the lowest is in Mexico (2.5).[3] Differences in rates of depressive disorders, alcohol consumption, proportion of older adults, levels of social isolation, and religiosity may all play a role in the rate of suicide (Goldsmith, 2001).

In the U.S., suicide rates among African American women, particularly in middle age, are very low (Goldsmith, 2001). In California, the lowest suicide rate is among Latinos between 55 to 64 years of age (California Department of Public Health [CDPH], 2006). Sociocultural differences between population groups and between individuals, such as social connectedness, family relations, marital status, parenthood, and participation in religious activities and beliefs (including negative moral attitudes toward suicide), may all be important underlying factors (Goldsmith et. al., 2002).

### Who Dies By Suicide?

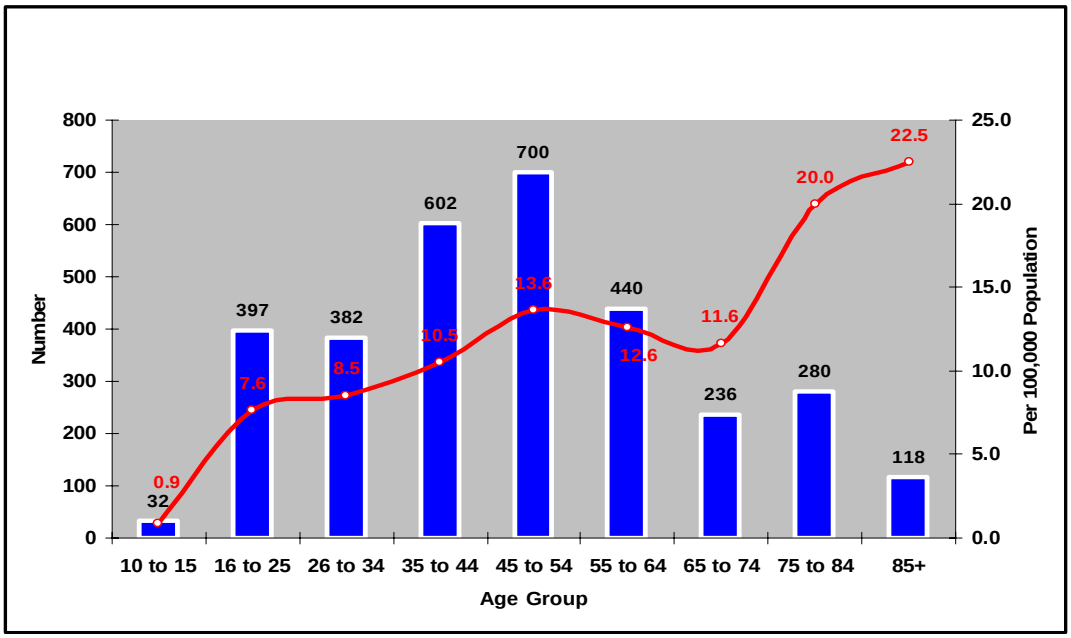
[3] These data should be interpreted cautiously, as they are compiled from various sources and studies. They may have employed different criteria and methods, which may result in under-reporting of actual suicide deaths.

The age-adjusted[4] rate of suicide within the general population of the state is 8.8 per 100,000 (CDPH, 2005)[5]. According to the California County Health Status Profiles report, a three-year average number of suicide deaths from 2003 to 2005 shows that the highest suicide rate among California counties was in Humboldt County (20.0), and Los Angeles County had the lowest rate (7.2) (CDPH)[6]. In 2004, over 16,000 individuals were hospitalized for self-inflicted injuries in California (46.0) (CDPH).

*Age*

The *rate* of suicide increases significantly with advanced age (Figure 1). In California, adults over the age of 85 have the highest suicide rate in the state, at 22.5 (CDPH, 2005). However the largest *numbers* of suicide deaths occur in the age range of 45 to 54, as shown in Figure 1. Of the 3,187 individuals who died by suicide in 2005, over 40 percent (1,322) were adults between 35 to 54 years of age.

**Figure 1. Suicide Death Rates and Number of Deaths in California by Age, 2005. (CDPH)**




Depression and chronic illness are significant risk factors for suicide among older adults (Centers for Disease Control and Prevention [CDC], July 7, 2006).

[4] An age-adjusted rate allows for comparisons between groups with different age distributions.
[5] Throughout this report, all references of rates are per 100,000 population.
[6] The County Health Status Profiles Report is available at www.cdph.ca.gov/programs/OHIR/Documents/Profiles2007.pdf

Depression is linked to multiple adverse health outcomes, including premature mortality and diminished quality of life, and it is a strong predictor of suicide (Chapman and Perry, 2008). Higher rates of depression are found among older adults receiving in-home care or living in institutions and among those with chronic diseases such as asthma, chronic obstructive pulmonary disease, arthritis, and heart disease (2008).

Older adults are becoming an increasing proportion of the state's growing population, particularly as the baby boomers approach age 65. In 2000, the population of people over the age of 65 was over 3.6 million; in 2010 it is projected to be over 4.4 million; and in 2020, it may exceed 6.3 million (State of California, 2007). Thus, it is becoming increasingly important to pay attention to the high rates of suicide among older adults.

Another way to understand the data is to consider leading causes of death in California (Table 4). Although the rate of suicide among older adults is high, suicide is not one of the ten leading causes of death among adults aged 65 and older. Among youth and young adults between 16 to 25 years of age, suicide is the third leading cause of death.

Nationally, more teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, strokes, pneumonia, influenza, and chronic lung diseases combined (U.S. Dept. of Health and Human Services, 2001 [DHHS]). Among specific groups, including females from 10 to 19 years of age and males between 15 to 19 years of age, national data indicate an increase in suicide rates in recent years (Centers for Disease Control and Prevention [CDC], Sept. 7, 2007).

A University of California (UC) survey revealed that nine percent of its students had serious suicidal ideation, and up to 80 percent of those had not received mental health services (UC Student Mental Health Committee, 2000). Another UC study (2006) found that the incidence of suicidal behavior, including attempts, the number of students taking psychotropic medications, and the number of mental health and crisis visits to student health centers increased significantly between 2000 and 2005. Based on the number of reported attempts and reported suicidal ideation, the students identified as at highest risk for completing suicide included graduate students; gay, lesbian, bisexual, transgender, and questioning (GLBTQ) students; international students; and racially and ethnically underrepresented students (UC Student Mental Health Committee, 2006).

## Table 4. Ten Leading Causes of Death by Age, California, 2005. (California Department of Public Health).

**10 Leading Causes of Death, California**
**2005, All Races, Both Sexes**
**(County of Residence)**

| Rank | Age Groups | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | <1 | 01-05[a] | 06-09[b] | 10-15 | 16-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75-84 | 85+ | All Ages |
| 1 | Congenital Anomalies 684 | Unintentional Injury 222 | Unintentional Injury 89 | Unintentional Injury 191 | Unintentional Injury 1,563 | Unintentional Injury 1,203 | Unintentional Injury 1,744 | Malignant Neoplasms 4,936 | Malignant Neoplasms 9,323 | Malignant Neoplasms 12,953 | Heart Disease 18,998 | Heart Disease 25,367 | Heart Disease 64,689 |
| 2 | Short Gestation 453 | Congenital Anomalies 76 | Malignant Neoplasms 47 | Malignant Neoplasms 74 | Homicide 985 | Homicide 577 | Malignant Neoplasms 1,562 | Heart Disease 3,499 | Heart Disease 6,189 | Heart Disease 8,991 | Malignant Neoplasms 16,422 | Malignant Neoplasms 8,528 | Malignant Neoplasms 54,613 |
| 3 | Maternal Pregnancy 174 | Malignant Neoplasms 62 | Congenital Anomalies 16 | Homicide 73 | Suicide 397 | Malignant Neoplasms 409 | Heart Disease 1,164 | Unintentional Injury 2,019 | Unintentional Injury 1,191 | Chronic Low. Resp. Dis. 2,622 | Chronic Low. Resp. Dis. 5,139 | Cerebro-vascular 6,431 | Cerebro-vascular 15,551 |
| 4 | SIDS 151 | Homicide 37 | Chronic Low. Resp. Dis. 7 | Congenital Anomalies 39 | Malignant Neoplasms 282 | Suicide 382 | Suicide 602 | Liver Disease 1,116 | Diabetes Mellitus 1,173 | Cerebro-vascular 1,986 | Cerebro-vascular 5,015 | Alzheimer's Disease 4,920 | Chronic Low. Resp. Dis. 13,167 |
| 5 | Placenta, Cord, Membranes 90 | Heart Disease 19 | Heart Disease 7 | Suicide 32 | Heart Disease 118 | Heart Disease 280 | HIV 468 | Cerebro-vascular 703 | Chronic Low. Resp. Dis. 1,140 | Diabetes Mellitus 1,678 | Diabetes Mellitus 2,360 | Chronic Low. Resp. Dis. 3,722 | Unintentional Injury 10,926 |
| 6 | Neonatal Hemorrhage 89 | Influenza & Pneumonia 19 | Homicide 6 | Heart Disease 25 | Congenital Anomalies 56 | HIV 97 | Liver Disease 420 | Suicide 700 | Cerebro-vascular 1,046 | Influenza & Pneumonia 772 | Alzheimer's Disease 2,347 | Influenza & Pneumonia 3,680 | Alzheimer's Disease 7,694 |
| 7 | Resp. Distress 89 | Cerebro-vascular 8 | Influenza & Pneumonia 6 | Chronic Low. Resp. Dis. 9 | Complicated Pregnancy 29 | Liver Disease 57 | Homicide 385 | Diabetes Mellitus 660 | Liver Disease 1,039 | Unintentional Injury 705 | Influenza & Pneumonia 2,291 | Diabetes Mellitus 1,500 | Diabetes Mellitus 7,679 |
| 8 | Bacterial Sepsis 68 | Chronic Low. Resp. Dis. 6 | Benign Neoplasms 4 | Benign Neoplasms 8 | Cerebro-vascular 26 | Diabetes Mellitus 55 | Cerebro-vascular 267 | HIV 451 | Suicide 440 | Liver Disease 682 | Unintentional Injury 1,035 | Hypertension 1,351 | Influenza & Pneumonia 7,537 |
| 9 | Unintentional Injury 65 | Perinatal Period 6 | Cerebro-vascular 3 | Influenza & Pneumonia 7 | Diabetes Mellitus 25 | Congenital Anomalies 54 | Diabetes Mellitus 219 | Chronic Low. Resp. Dis. 391 | Influenza & Pneumonia 369 | Nephritis 436 | Parkinson's Disease 883 | Unintentional Injury 887 | Liver Disease 3,819 |
| 10 | Intrauterine Hypoxia 62 | Meningitis 5 | Diabetes Mellitus 1 | Diabetes Mellitus 6 | HIV 15 | Cerebro-vascular 51 | Influenza & Pneumonia 107 | Viral Hepatitis 254 | Nephritis 307 | Hypertension 388 | Hypertension 882 | Athero-sclerosis 845 | Suicide 3,188 |

Source: California Department of Public Health. 2005 Death Records.

[a] Septicemia also ranked 10th.

[b] Liver Disease, Meningococcal Infection, Perinatal Period, and Septicemia also ranked 10th.

*Sex*

In California, males are three times more likely to die by suicide than females (CDPH). After the age of 14, rates of suicide are significantly higher among males regardless of age, race, or ethnicity (Table 5, Table 6).

However, it is important to note that women attempt suicide three times as frequently as men and are more likely to be hospitalized for self-inflicted injuries, primarily from poisoning or hanging (CDPH). Sixty percent of hospitalizations for self-inflicted injuries are among females (CDPH, 2004). Women are both more likely than men to attempt suicide and also to have a history of sexual abuse (Garcia et. al., 2002; Dube et. al., 2001; DHHS, 2005). The National Lesbian

Health Care study, a survey of over 1900 Lesbian women in 50 states, found that 40 percent of respondents had experienced trauma, from childhood sexual or physical abuse to rape (Bradford et. al, 1994).
The difference between the sexes in suicidal behavior begins to emerge in adolescence. Surveys of eighth grade students in California, Arizona, Nevada, and Wyoming found that girls were more likely to report suicidal ideation and attempts than boys, and that girls were also more likely to feel like they had less control over their environment (Evans et. al, 2005).

**Table 5. Suicide Death Rates by Age and Sex, California, 2005. (CDPH)**

| Age Groups | Total | Rates among males | Rates among females |
|---|---|---|---|
| All Ages | 8.8 | 14.1 | 5.9 |
| 1-4 | - | - | - |
| 5-14* | 0.3 | 0.4 | 0.2 |
| 15-24 | 6.9 | 10.9 | 2.6 |
| 25-34 | 8.5 | 13.0 | 3.8 |
| 35-44 | 10.5 | 15.8 | 4.9 |
| 45-54 | 13.6 | 19.8 | 7.5 |
| 55-64 | 12.6 | 19.3 | 6.3 |
| 65-74 | 11.6 | 19.5 | 4.9 |
| 75-84 | 20.0 | 39.6 | 6.1 |
| 85 and older | 22.5 | 53.5 | 6.6 |

**Table 6. Suicide Death Rates by Race, Ethnicity, and Sex, California, 2005. (CDPH)**

| Race/Ethnicity | Males | Females |
|---|---|---|
| Whites | 19.3 | 5.9 |
| African Americans | 9.1 | 2.9 |
| Asians | 7.9 | 2.9 |
| Latinos | 7.5 | 1.4 |
| 2+ races* | 5.9 | 3.3 |
| **General Population** | 14.1 | 4.0 |

*Note that this rate is considered unreliable because relative standard error is greater than or equal to 23 percent.

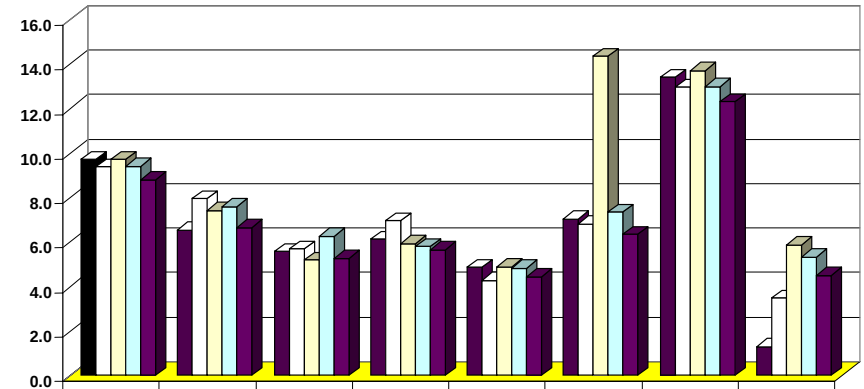
In addition to mortality rates, the public health burden of suicide is also measured in terms of years of potential life lost and value of lost earnings. One study that used this approach found that middle-aged men contribute disproportionately to the burden (Knox and Caine, 2005). The study suggested that concerns around stigma and help-seeking behavior may contribute to this problem among men.

*Race and Ethnicity*

Rates of suicide differ significantly among racial and ethnic groups (Figure 2). The most recent available data in California indicate that in 2005 Whites had the highest rate of suicide followed by Native Americans (American Indians), Pacific Islanders, African Americans (Blacks), Asians, people identifying as two or more races, and Latinos. These rates vary among counties. It is important to note that even a small increase in the number of deaths can dramatically increase the rate in population groups that are relatively small in number, as evidenced by the increase in the suicide rate among Pacific Islanders in 2003 (CDPH).

California data are consistent with national data, which indicate that Whites account for 84 percent of all suicide deaths (CDC, 2005). However, despite the very high suicide rates among White males, few prevention programs target this demographic; this group is also one of the least likely to seek mental health treatment (Pirkis and Burgess, 1998).

**Figure 2. Age-adjusted suicide death rates by race and ethnicity, California residents, 2001-2005. (CDPH).**




| | TOTAL | AMERICAN INDIAN | ASIAN | BLACK | LATINO | PACIFIC ISLANDER | WHITE | TWO OR MORE RACES |
|---|---|---|---|---|---|---|---|---|
| 2001 | 9.7 | 6.5 | 5.6 | 6.1 | 4.9 | 7.0 | 13.4 | 1.3 |
| 2002 | 9.4 | 7.9 | 5.7 | 7.0 | 4.3 | 6.8 | 13.0 | 3.5 |
| 2003 | 9.7 | 7.4 | 5.2 | 5.9 | 4.9 | 14.3 | 13.7 | 5.9 |
| 2004 | 9.4 | 7.6 | 6.3 | 5.8 | 4.8 | 7.3 | 13.0 | 5.3 |
| 2005 | 8.8 | 6.6 | 5.3 | 5.7 | 4.4 | 6.3 | 12.3 | 4.5 |

**Note: Includes unreliable rates for American Indian, Pacific Islander, and Two or More Races (2001,2002).**

Historically, African Americans have had lower rates of suicide than other racial and ethnic groups. However, national studies have noted that the suicide rate among African American males under the age of 35 has increased significantly over the last two decades, particularly among young men in the northern and western states (Willis et al., 2003).

Among Latinos, suicide attempts are most prevalent in young females under the age of 18; data from the national Youth Risk Behavior Surveillance study of youth in grades seven, nine, and eleven found that more Latina students, nearly one quarter, reported suicidal ideation and behaviors than their White or African American female peers (CDC, 2006; Fortuna et. al., 2007).

*Limitations of Race and Ethnicity Data*

It is important to note that the suicide rates for American Indians and Pacific Islanders are considered unreliable either to small population size or the relatively small number of events that are reported (less than 20 per year). National data strongly indicate that suicide is the leading cause of death among

American Indians and Alaskan Natives between 15 and 24 years of age (CDC, 2005). From 1999 to 2004 young men in this population had a higher suicide rate (27.99) than any other racial and ethnic group of the same age (CDC, 2005). Furthermore, suicide is the second leading cause of death among Asian American/Pacific Islander youth from ages 15 to 24 (CDC, 2005). Among the general population of 15 to 24 year olds, suicide is the third leading cause of death, indicating that nationally, youth who are American Indian, Alaska Native, and Pacific Islander are at disproportionately higher risk of suicide.

The discrepancy between the low number of reported incidents of suicide among American Indian and Pacific Islanders in California and what is known from national data suggest that suicide prevention research and surveillance activities need to determine whether this discrepancy indicates a significant difference between California's population and that in other states, or whether data reporting and analysis for all population groups that may currently be underreported need to be strengthened.

*Mental Illness*

The National Violent Death Reporting System found that nearly half of suicide cases involve at least one documented mental health diagnosis (CDC, July 7, 2006). It is estimated that as many as 90 percent of individuals who died by suicide had a diagnosable mental illness or substance abuse disorder (National Institute of Mental Health [NIMH], 2003). Certain psychiatric diagnoses increase the risk of suicide substantially. Among individuals diagnosed with a major mood disorder, a spectrum that includes major depression and bipolar disorder, up to 20 percent die by suicide (Rihmer and Kiss, 2002). The risk tends to be highest among those who have frequent and severe recurrences of symptoms (Jamison 2001).

Suicide is the leading cause of death among individuals with schizophrenia; nearly 6 percent complete suicide, with most suicide deaths occurring early in the illness, and up to 40 percent attempt suicide at least once (Palmer et al., 2005; Raymont, 2001).

Co-occurring substance and alcohol abuse exacerbates the risk of suicide. In one national study, individuals diagnosed with major depressive disorder who used drugs or engaged in binge drinking were significantly more likely to report suicidal thoughts and to attempt suicide than those with major depressive disorders who did not abuse alcohol or drugs (SAMHSA, 2006).

Issues of stigma and discrimination related to mental illness and suicide may negatively impact accurate identification and reporting of suicide deaths. Ascertaining suicidal intent in determining cause of death is often a challenge.

This challenge can be exacerbated by concerns about the impact of a determination of suicide on the families and others who lost a loved one and by concerns about confidentiality, particularly in small communities.

*Criminal Justice System*

Nationally, the number of individuals with mental illness who are in jails and prisons is higher than the number who are in psychiatric hospitals (Dumond et. al, 2003). More than half of all prison and jail inmates have a mental illness; this rate is three times that of the general population (Lyons, 2007).

Suicide is the third leading cause of death in California prisons (California Dept. of Corrections and Rehabilitation [CDCR]). Like other prison systems nationally, suicide deaths in California's prisons are predominantly among White males (CDCR).

In both jails and prisons across the country, White inmates have significantly higher rates of suicide than other races (U.S. Department of Justice, 2005). The rate of suicide among males and females does differ in prisons versus jails. In prisons, male and female inmates die by suicide at similar rates; however, in jails men are over 50 percent more likely to die by suicide than females. Finally, 80 percent of suicides occurred within the cell (2005).

The U.S. Department of Justice reports that between 1994 and 2003 suicide was the second leading cause of death for individuals in custody (2005). Nationally, suicide accounted for 32 percent of local jail inmate deaths between 2000 and 2002. Suicide rates in local jails were three times that in state prisons. Violent offenders were nearly three times as likely to die by suicide than other inmates in jails.

In prisons, the periods of highest risk for suicide are during the first month of incarceration and the first few weeks after release (Binswanger et. al, 2007; Pratt et. al, 2006). Nearly half of jail suicides occur within the first week of custody; almost one quarter of these are on the date of admission or the following day (U.S. Department of Justice, 2005).

One study that examined 1996 data found that in 40 percent of the 196 intimate partner homicide cases in California, the perpetrator also completed suicide (Lund and Smorodinsky, 2001). In these cases, the use of a gun and a perpetrator who was a White male were both significant predictors that the perpetrator would also complete suicide (Lund and Smorodinsky, 2001). Perpetrators and victims in these intimate partner homicide-suicide cases tended to be married and White, and almost all cases involved firearms. In comparison, less than half of homicides in which the perpetrator did not complete suicide

involved a firearm. Among older people that died by intimate partner homicide-suicide, the reasons were typically related to poor health or financial concerns.

*Veterans*

An analysis of data from national health surveys and the National Death Index from the middle 1980s to 1990s found that male veterans were twice as likely to die by suicide as the general male population, especially those who were White, less educated, and had physical disabilities (Kaplan et al., 2007).

A study of veterans in the Veterans Affairs (VA) health care system found that among veterans receiving treatment for depression, the rate of suicide was seven to eight times that of their counterparts in the general population (a rate of 88.25 among veterans versus a rate of 13.5 among the general population in 2004) (Zivn et. al., 2007). This study found that several trends in suicide deaths among veterans are unlike those found in the general population. For example, the risk is higher among younger, rather than older, individuals, particularly in the presence of conditions such as post traumatic stress disorder (PTSD) (Zivn et. al., 2007). Furthermore, the relative suicide rates of male and female veterans are not as far apart as those in the general population (Zivn et. al., 2007).

Data collected prior to the Iraq War estimated that suicide rates among veterans currently using VA facilities were 45.0 per 100,000 among those over the age of 65, and as high as 83.0 per 100,000 for those under age 65 (Department of Veterans Affairs, 2007).

Extrapolating from more recent national data, the VA estimates that there are 1,000 suicides per year among veterans receiving care through the VA health care system and as many as 5,000 per year among all veterans (2007). Some of the groups at highest risk include those with severe mental illnesses; combat-related PTSD; traumatic brain injury; traumatic amputation or disfigurement; military sexual trauma; and spinal cord injuries (2007).

Surveys of military personnel stationed in Iraq and Afghanistan indicate that as many as 17 percent met the criteria for major depression, generalized anxiety, or post-traumatic stress disorder (Hoge et al., 2004). This is significantly higher than the rates among the general population. Of those personnel, less than 40 percent sought mental health care, and many reported being concerned about being stigmatized and discriminated against because of their mental health problems (2004). These high rates of mental disorders and fear of stigma among those most in need indicate that suicide prevention planning must take into account the needs of veterans who have recently, or will soon be, returning from the active field of war.

Among populations with high rates of suicide - older adults, those with a mental illness or substance abuse disorder, and those who are homeless – a large number are also veterans. The VA estimates that approximately one-third of all adults who are homeless are veterans. Nearly half of homeless veterans have a mental illness, 70 percent suffer from alcohol or other drug abuse, and 56 percent are African American or Latino (Dept. of Veterans Affairs). The number of homeless Vietnam-era veterans is greater than the number that died in that war.

*Homeless Individuals*

Individuals who are homeless often meet many of the criteria for elevated suicide risk, such as serious and untreated mental illness, social isolation, poverty, and substance abuse. Yet the data about suicide in this population is limited (Christensen, 2006). Collecting accurate data about suicidality among individuals who are homeless presents a methodological challenge for many of the same reasons that put them at higher risk.

The ACCESS (Access to Community Care and Effective Services and Supports) program, a national Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration project at 18 sites nationally that served over 7,000 individuals experiencing serious mental illness and chronic homelessness, investigated the prevalence of suicidal ideation and suicide attempts. A study from a sample of individuals served in this project found that the lifetime prevalence of suicidal ideation was high (66.2 percent) (Desai et. al., 2003). Over 50 percent reported that they had attempted suicide, 26.9 percent reported an attempt that resulted in hospitalization for their injuries, and 8 percent reported an attempt in the previous 30 days (2003). Youth, co-occurring substance abuse, and psychiatric symptoms were all significantly associated with suicide attempts. Those who reported a recent attempt also reported higher rates of inpatient mental health care utilization.

Other studies have also found that individuals who are homeless longer than six months may be at particularly high risk of suicide (Langley et al., 2002). Furthermore, suicide rates are highest among individuals 30 to 39 years old, although co-occurring substance abuse significantly increases the risk among older individuals (Prigerson et al., 2003). Among homeless and runaway youth, factors such as depression, history of physical and sexual abuse, and having a friend who attempted suicide may all contribute to an increase in suicide risk (Yoder, 1999).

*Immigrants*

Several factors may influence the rates of suicide among certain groups, including accessibility of mental health services, especially services that are culturally and linguistically appropriate. Different cultural attitudes about suicide and mental health may also play an influential role in the willingness to seek help for mental health problems. For specific immigrant and refugee populations, factors related to acculturation and family conflict may play an important role (Fortuna et. al., 2007).

Riverside County is one of the fastest growing counties in California, primarily due to immigration. One study examined over 100,000 death certificates from first generation White immigrants who had died between1998-2001 (Nasseri, 2007). There was significantly higher mortality from suicide among non-Hispanic White immigrants (including those born in Europe, the Middle East and North Africa), than U.S.-born individuals of the same ethnicity.

Another study of coroner case records from the same time period examined some of the factors associated with the higher suicide risk among immigrants. Those at highest risk of suicide were more recently arrived; divorced, separated, or widowed; male; middle aged or older; and White (Kposawa, McElvain, and Breault, 2008).

*Rural Populations*

Rural states have the highest rates of suicide in the country, particularly among adult and older adult males and youth. One study found that among people diagnosed with bipolar disorder, those who live in rural areas have higher rates of suicide attempts than their urban counterparts (Gamm et. al., 2003). Possible contributing factors to this higher rate include the availability and quality of mental health services, increased impact of stigma due to reduced anonymity in smaller communities, higher poverty rates, and the larger percentage of older adults in the population (Advancing Suicide Prevention, 2005; Gamm et. al., 2003)

One study compared the suicide rates in urban and rural counties in California with the per capita number of health (licensed physicians) and mental health providers in those counties. The study confirmed that the rates of suicide were higher in rural counties, and also that the rate of suicides by firearm were higher the more rural the county (Fiske et. al., 2005). However, the rate of suicide was not correlated with the per capita number of health and mental health providers in the counties (Fiske et. al., 2005). This study was not able to address the issue of the quality and accessibility of appropriate services in rural areas. More research needs to be done to determine if issues of quality and accessibility play a role in the higher suicide rates in rural areas.

*Sexual Minority Populations*

Data from multiple national studies (including the National Longitudinal Study of Adolescent Health, National Lesbian Health Care Survey, National Latino and Asian American Survey, and the Urban Men's Health Study) have demonstrated that lesbian, gay, and bisexual individuals, particularly adolescents and young adults, have significantly higher rates of suicidal ideation and suicide attempts than their heterosexual counterparts (Silenzio et. al., 2007; Russell and Joyner, 2002; D'Augelli et. al., 2005; Ramedi et. al., 1998; Bradford et. al, 1994; Cochran et. al., 2007).

Research within California confirms the national data:

- A survey of over 2800 men who either identified as gay or bisexual or as having had sex with other men in four U.S. cities, including Los Angeles and San Francisco, reported that over 20 percent of respondents had made a plan and another 12 percent had attempted suicide at least once, typically before age 25 (Paul et. al., 2002). This represents a three-fold increase in risk among gay and bisexual men compared to men in the general population.
- A survey of over 500 Los Angeles County men between the ages 18 to 24 years old who identified as gay, bisexual, or questioning or having had sex with a man found that ten percent had seriously considered suicide, four percent had developed a plan, and another four percent had attempted suicide (Kipke et. al., 2007). This group was also characterized by low rates of access to health care and health insurance coverage.
- A San Francisco survey of over 523 transgender individuals found that nearly one-third of the respondents had attempted suicide (Clements-Nolle, et. al., 2006). High rates were associated with multiple co-occurring risk factors that are commonly associated with elevated suicide risk among many populations, such as White, under 25 years of age, unemployment, history of incarceration, depression, and substance abuse. This study is unique in that it was able to identify experience of gender discrimination and physical victimization as independent factors that each increase the prevalence of attempted suicide (Clements-Nolle, et. al., 2006).

Analysis of factors associated with this elevated risk indicates that coping with stigma and discrimination based on sexual orientation can be a particularly challenging issue for adolescents and young adults. A survey of over 1700 youth aged 12 to18 years old in an upper middle class community in California found that lesbian, gay, and bisexual youth were at higher risk for a range of health and mental health problems, especially those who reported being less comfortable with or uncertain about their sexual orientation (Lock and Steiner 1999).

Social support in a community of peers is especially important to this vulnerable population, especially when family and school environments are stressful (D'Augelli et. al., 2005). One longitudinal study of lesbian, gay, and bisexual youth between the ages15 to 19 in the New York City area found that the strongest predictive factors of suicide risk were a history of parental psychological abuse and more gender atypical behavior in childhood, especially among males (D'Augelli et. al., 2005).

Among gay or bisexual men, factors associated with higher risk included a perceived hostile environment related to their sexuality, less education, lower income, and lower employment (Paul et. al., 2002). Native Americans, older men, and men who were bisexual or did not identify as any specific sexual orientation had the highest prevalence of suicide attempts. Attempts were also higher among men who reported adverse childhood experiences, such as parental substance abuse, repeated childhood physical abuse, and childhood sexual coercion. This study found that the age of disclosure of sexual orientation has been steadily declining over time, but that reported harassment has increased dramatically among younger generations.

*Women with Perinatal Depression*

According to the National Women's Health Information Center, a service of the U.S. Department of Health and Human Service's Office on Women's Health, perinatal depression occurs during pregnancy or within the first year after childbirth. Although the exact prevalence of perinatal depression is not known, it is believed to be one of the most common complications women experience during and after pregnancy. Since some of its symptoms are very similar to typical changes that occur around pregnancy and birth, perinatal depression may be underrecognized.

Although suicide rates among women who are pregnant or recently gave birth are lower than the general population of women, suicide is the second leading cause of postpartum maternal deaths (Lindahl et al., 2005). Up to 14 percent of women report suicidal ideation during pregnancy and the postpartum period (Lindahl et al., 2005). Women who have a history of depression or postpartum depression are at 70 times greater risk of suicide than those without this psychiatric history (Appleby et. al., 1988). Throughout the first year after giving birth, over 30 percent of women who report postpartum depression continue to have depressive symptoms, and less than half improve within the first three months after giving birth (Chudron et. al., 2006).

There may also be a link between maternal depression, recurrence of depression, and later behavioral problems in the child (Joseffson and Sydsjo,

2007). Extended maternal depression can have a negative impact on attachment between mother and child, which may put the child at increased risk of developing behavioral problems. Although perinatal depression was not specifically addressed in the Adverse Childhood Experiences Study, the study did find that children who grew up in a household where someone had a serious mental illness were more likely to attempt suicide at least once in their lifetime (Dube et. al., 2001). Therefore it is important that pregnant women are screened for factors that may put them at higher risk for perinatal depression, including a history of depression and/or postpartum depression, throughout the year following birth in order to successfully recognize and treat maternal depression but also to reduce the likelihood of adverse impacts on the child.

Postpartum psychosis is believed to be much rarer, occurring in approximately one or two out of every 1000 births, and typically begins within the first six weeks after childbirth. The risk of postpartum psychosis is higher among women who have significant mental illnesses, specifically bipolar disorder or schizoaffective disorder. It can include delusions, hallucinations, sleep disturbances, obsessive thoughts about the baby, and rapid mood swings.

**Means of Suicide**

In a study of survivors of suicide attempts, almost half reported that less than one hour had passed between their decision to complete suicide and the actual attempt; another 24 percent indicated it was less than five minutes (Simon et. al., 2001). The crisis leading up to suicide and suicide attempts is often short-lived, containing some impulsivity and ambivalence (Daigle, 2005). Restricting access to lethal means can put time between the impulse to complete suicide and the act itself, allowing opportunities for the impulse to subside or warning signs to be recognized and interventions to occur.

Firearms are used in over 40 percent of suicides in California, followed by hanging (26.4 percent) and poisoning (19.4 percent) (CDPH, 2005). Almost half of males who died by suicide used a firearm (CDPH, 2005). The most common method used in completed suicides among females is poisoning[7] (37.5 percent) (CDPH, 2005). These three methods account for 87 percent of all suicide deaths (CDPH). Poisoning is the leading means of self-inflicted, non-fatal injury, with alcohol and drug overdoses accounting for 77 percent of all poisoning incidents (CDPH).

[7] The CDC defines a poison as any substance that is harmful to the body when eaten, breathed, injected, or absorbed through the skin. Poisoning occurs when too much of some substance has been taken, and generally the deaths that occur involve abuse of prescription or illegal drugs; the definition does not include adverse reactions to medications that were taken correctly.

Addressing access to controlled substances and firearms is one way to prevent many suicides. The National Violent Death Reporting System (NVDRS) found that in 82 percent of firearm suicides among youth under 18, the firearm belonged to a family member, underscoring the importance of attention to safe storage of firearms in the home (2007). In many states, laws and practices do not uniformly ensure that information on persons restricted from possessing firearms is appropriately captured and available to the National Instant Criminal Background Check System (White House, 2007).

One explanation that has been suggested for the substantially higher rate of completed suicides among males is that females use less lethal means. Among females, hanging or suffocation accounts for 71.4 percent of suicide deaths between 10 and 14 years of age, 49 percent of suicides between 15 and 19 years of age, and 34.2 percent between 20 and 24 years of age (CDC, Sept. 7, 2007). A review of over 600 coroner records in Riverside County, California, from the years 1998 to 2001 found that although women were over four times more likely to use poisoning than men, hanging, a highly lethal method was equally as likely to be used by both sexes (Kposawa and McElvain, 2006). Furthermore, although women were 73 percent less likely to use firearms than men, they were the second most common means they did use.

The results of this study are supported by more current statewide data in California. Males and females are equally as likely to use hanging as a method (26.5 percent and 26.2 percent respectively), and among females, firearms were the third most common method and were used on over 20 percent of deaths (CDPH, 2005).

National data indicate that the use of lethal means other than firearms has increased, particularly among certain age and sex groups. Poisoning deaths accounted for 28 percent of the increase in the national suicide rate between 1999 and 2004[8] (CDC, Dec. 14, 2007; CDC, Feb. 9, 2007). In this same five-year period, the rate of suicide by hanging or suffocation increased, especially among adults ages 20 to 29 and 45 to 54 (CDC, Dec. 14, 2007).

Given that the means to complete suicide by hanging or suffocation are usually more widely accessible and more difficult to control, prevention programs need to address access to lethal means in concert with education about suicide and psychosocial interventions that target groups at high risk.

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[8] The CDC acknowledges that establishing whether a poisoning death was intentional or not is difficult. Misclassifications may occur, underscoring the importance of partnering with medical examiners and coroners to ensure that causes of death are reported as accurately as possible.

Some research has suggested that individuals have a preference for a given means, and that if prevented from using it, an attempt may not occur (Daigle, 2005). The contagion effect, personal ideas, and cultural factors all are likely to come into play when an individual is determining means (Daigle, 2005).

## The Cost of Suicide and Suicide Attempts

The emotional cost of suicide has both immediate and far-reaching effects on families and communities. It is estimated that each suicide seriously impacts at least six other people (McIntosh, 2006). In addition to grieving the loss of the individual who took his or her own life, survivors – family members, caregivers, and friends – may themselves be at increased risk of suicide. The stigma associated with suicide may lead to reluctance to talk about the problem or to seek out social supports and mental health services.

Beyond the human suffering and emotional toll of suicide and self-inflicted injuries, there are also financial costs. The economic burden of suicide is spread throughout a variety of systems, including education, hospitals, primary care, mental health, and corrections. To estimate these costs, a formula has been derived based on costs incurred by victims, families, employers, government programs, insurers, and taxpayers (Suicide Prevention Resource Center [SPRC]). Estimates of the cost of self-injuries take into account hospitalizations and follow-up treatment; coroner and medical examiner costs; and transport, emergency department, and nursing home costs. Lifetime productivity estimates take into account lost wages, fringe benefits, and costs related to permanent or long-term disability for each individual who attempts or dies by suicide.

Using this formula based on suicide data from 1999 to 2003, the average medical cost per suicide in California was $4,781 and the average lifetime productivity loss for each individual was $1,219,333. The resulting cost of suicide deaths in a given year is nearly $15 million in medical costs in addition to the $3.8 billion in lost lifetime productivity for the individuals who die by suicide in a given year.

In 2003 there were 16,495 hospitalizations for suicide attempts in California. The average medical cost per hospitalization was $12,380, and the average work-loss per case was $14,058 (SPRC). This amounts to $204 million in medical costs and over $230 million in lost productivity. The resulting cost of suicide attempts in a given year in California is approximately $435 million.

Based on these figures, the combined estimated cost for suicides and suicide attempts in California is $449 million per year, plus the $3.8 billion in lifetime productivity loss.

# Part 2 – Strategies for Suicide Prevention

Suicide prevention encompasses a wide range of prevention, intervention, and postvention strategies that reduce suicidal behavior and its impact on family, friends, and communities. This spectrum includes promotion and prevention strategies that offer education, foster resiliency and enhance protective factors in individuals and communities; building the capacity of providers and systems to offer appropriate services including interventions to address mental health problems early and to reduce suicidal behaviors; and follow-up care services for those who have survived a suicide attempt and for family members and others who have suffered the loss of a loved one. Suicide prevention must include research and surveillance to further understand demographic, cultural, social, and biological factors that reduce risk factors and promote help-seeking behavior. Evaluation and program improvements are other essential elements (National Strategy for Suicide Prevention, 2001; California Strategy for Suicide Prevention, 2005; Maris et. al., 2000).

## Creating a System of Suicide Prevention

A system of suicide prevention would include a range of gender-specific services and programs designed to effectively meet the needs of individuals of all ages and from diverse racial, ethnic, cultural, and linguistic backgrounds. The success of the system will be judged not solely on the value of any one component or service but rather how well the parts are coordinated and build upon one another. Linkages are critical because it can be anticipated that increased community outreach and education efforts to promote mental health, build resiliency and increase awareness of the suicide warning signs may result in increased service demands further along the intervention spectrum (e.g., screening and assessment, early intervention program, crisis services). Fragmentation of systems presents a fundamental challenge of effective access and continuity of care that can cost lives (Raingruber, 2003).

To ensure that the system for suicide prevention is effective, it is critical to assess the assets and gaps, make a plan, implement and reassess. To create such a system, coordination and partnerships must occur at multiple levels. Models of collaboration need to be developed to ensure that professionals from different disciplines and systems that have important roles in the process of evaluating, treating, and preventing suicidal behavior can communicate and coordinate activities.

*Coordination – State Level*

To achieve maximum benefit and efficiency throughout our large state, it is imperative that a centralized, coordinating body for the various suicide prevention activities is charged to effectively reach and serve the diverse populations of California.

This strategy has been effective in other states. Maryland implemented a model state prevention and awareness program and now has the fifth lowest suicide rate in the nation. Colorado has established a similar office, resulting in increased federal funding for suicide prevention and successful coordination of training for gatekeepers throughout the state (Westray, 1998).

On February 6, 2008, the California Department of Mental Health, in collaboration with Assembly Member Mary Hayashi, announced the establishment of an Office of Suicide Prevention. This office will provide a single point of contact and a central point of dissemination for information, resources, and data about suicide and suicide prevention programs. It will serve as a liaison with national partners, such as the Suicide Prevention Resource Center (SPRC) and the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as other states. The office will ensure that activities build upon resources and materials where they already exist, and it will provide expert consultation on local suicide prevention plans and activities.

The California Office of Suicide Prevention will support integration of resources and activities for suicide prevention through various state and county systems and organizations. It will centralize coordination of strategic suicide prevention, intervention, postvention, and research activities throughout the state, including dissemination of model training curricula and service guidelines targeted to different professional groups and settings. It will provide leadership in developing learning communities among the diverse partners throughout California and among stakeholders within the counties, through such activities as disseminating information for community planning and conducting leadership training and capacity-building institutes. Additionally, the Office of Suicide Prevention would be a partner in the development of social marketing efforts focused on increasing community awareness and education, addressing stigma, and reducing suicidal behaviors.

Finally, the office will oversee the development of a research agenda to fill gaps in knowledge about suicide and suicidal behavior of Californians from diverse backgrounds, and it will aid in the evaluation of interventions to ensure they are effective. It will also coordinate periodic review and update of the *Strategic Plan on Suicide Prevention*, including tracking selected indices of suicidal behavior over time to provide accountability.

*Coordination—Local Level*

Many of the partners in a local system of suicide prevention are entities with county, municipality, or district-wide jurisdictions. Local coordination efforts need to include assessment, planning, implementation, and evaluation of the wide range of suicide prevention efforts needed at the community level.

Community-wide and targeted social marketing strategies are a critical component of the prevention efforts. Campaign activities should be designed to outreach to populations at risk, educate the general public on warning signs and resources, and engage with local media outlets on appropriate reporting guidelines. The messages and materials used should be culturally and linguistically appropriate as well as specific to the age and gender of the target population. Greater success may be achieved by connecting public education with supportive programs and policies.

Many effective practices integrate suicide prevention into existing community settings and services and utilize key points of contact or "gatekeepers," such as community health workers or promotoras, school staff, primary care providers and staff, and Area Agency on Aging programs (Kataoka et. al., 2007; Muehlenkamp and Gutierrez, 2007). These strategies are particularly effective for groups that are underserved by the traditional mental health system and are more likely to be identified by or seek help through other community supports. Some strategies offering a more effective response to suicide prevention and suicide include co-location of mental health services and primary care services, integrating mental health services into school-based clinics and aging services, and cross-discipline suicide assessment and intervention training. Working with youth development programs at schools, recreation centers, churches, and other locations also serve as possible venues for teaching problem-solving skills, conflict resolution and building resiliency; all of which play a role in suicide prevention.

To effectively prevent suicide, it is critical that each county have well-coordinated crisis response services. These services should be able to respond to acute, emergency situations involving emergency department and hospital staff, mental health providers, and law enforcement personnel. Crisis response services should also include hotlines and mobile outreach teams so that help is readily available when, and where, needed. Easily accessible and up-to-date directories of local suicide prevention and intervention resources would benefit individuals at risk, the general public, and providers in different systems. Safety plans for facilities, such as school campuses, increase preparedness to effectively respond to a crisis, including suicide attempts.

Hospital emergency departments often treat individuals with self-inflicted injuries; however, discharge planning procedures for emergency departments vary in their

provision of referrals for professional mental health assessments and follow-up services (Baraff et. al., 2006). There needs to be consistency across hospital, emergency department, and other inpatient settings to implement protocols for follow-up care and effective referral to ensure continuity of care that can save lives.

Peer support models can play an essential role as part of a coordinated system by improving quality of life, fostering recovery and resiliency, and preventing a crisis from developing. Support services provided by those who have experienced suicidal feelings, thoughts, and attempts, and who have survived and rebuilt their lives, can play a vital role in preventing suicide and in preventing the trauma that often accompanies the need for acute, emergency interventions. Peer support programs typically offer short-term, residential crisis services administered by peers; warm lines[9]; programs to promote health, wellness, and recovery; and forums to educate the public about mental illness and mental health.

The factors surrounding a suicide death are often complex and the stigma of suicide may influence the accuracy of reporting, which can impact the ability to identify systemic changes that may be necessary to prevent future deaths (Timmermans, 2005). A review of the local data and findings would be helpful to determine where additional attention to existing policies, services, or practices needs to be focused.

*Enhancing Mental Health Early Intervention and Treatment*

Intervention activities should target periods of time when suicide risk is high, such as initial onset of a mental illness and immediately after a hospital discharge (Deisenhammer et. al., 2007; Raymont, 2001). However, one of the most promising ways to prevent suicide and suicidal behavior is through recognition of early signs of mental health problems stemming from depression, loneliness, and other needs (Goldsmith et. al., 2002). Psychosocial therapy that strengthens problem-solving skills can help to address the feelings of hopelessness and of being overwhelmed and unable to change negative situations that lead to increased risk of suicide (Gray and Otto, 2001). Due to the strong link between severity or recurrence of episodes of serious mental illness and risk of suicide, consistent and appropriate treatment is crucial to suicide prevention (Jamison, 2001). In addition to risk factors among the general population, individuals diagnosed with a serious mental illness have other specific risk factors, such as severity of symptoms and numerous relapses (Raymont, 2001).

[9] Warm lines are phone lines staffed by peers that provide support and education. Warm lines are generally intended to help prevent a situation from developing into a crisis.

Routine screening for early identification of risk factors for mental illness and suicide in primary care settings has been shown to be a promising practice in certain settings (Stroul, 2007). Depression can lead to an increased risk of suicide, therefore identification of and early intervention for depression is an important strategy for preventing an individual's condition from becoming acute. For example, postnatal screening for depression is associated with a three-fold increase in detection of postpartum depression among women (Georgiopoulos et. al., 2001). The U.S. Preventive Services Task Force recommends screening tools for depression in primary care settings. There are several examples of depression screening tools, such as the "PHQ-9 Two-Question Screen". The PHQ-9 asks two questions and includes a nine-symptom checklist that the primary care professional uses to assess potential mental health problems, including depression. Another example of a successful screening process within the primary care setting is the "Four Quadrant Model", based on a similar model that the National Council for Community Behavioral Healthcare developed in 1998. This model separates individuals undergoing screening into four quadrants, or categories, of behavioral health and physical health, depending on the severity of their needs in each area. The model addresses a broad spectrum of health and mental health issues and co-occurring disorders, including various stages of depression.

With enhanced screening efforts comes the responsibility to ensure that prevention programs and community services and supports that are culturally and linguistically competent, participant-driven, recovery-based, and trauma-informed are available to people who need them. A focus group study administered by the California Network of Mental Health Clients found that where there is a lack of voluntary, community-based mental health services and supports, many mental health clients who seek services fear that overly restrictive modes of treatment will be the only services available in a suicide crisis.

*Sharing Information between Systems*

Recent events have highlighted the issue of confidentiality laws and information sharing related to mental health. The *Report to the President on Issues Raised by the Virginia Tech Tragedy* (2007) found that there is variability in understanding confidentiality laws that can result in confusion and barriers between legitimate information sharing among service providers and systems.

Confidentiality laws can be complex and often differ from state to state. States that allow for disclosure of mental health information usually limit it to diagnosis, prognosis, and information regarding treatment, generally medication (DHHS, 1999). Additionally, providers, clients, family members, and others disagree about when disclosure is appropriate (DHHS, 1999). Confidentiality issues are of

particular concern for the mental health system because of the ongoing problems of stigma and discrimination associated with mental illness. Until this is addressed, confidentiality issues will continue to be a significant challenge for strategies that seek to integrate systems and services.

## Targeted Approaches

*Suicide Prevention Hotlines*

Suicide prevention hotlines are an effective way for people in crisis to reach out for help, and those who use the lines report that they are helped by the calls. Surveys of individuals who have used hotlines indicate that their level of emotional distress and suicidal ideation are decreased by the end of the calls (Gould et. al., 2007; Kalafat et. al., 2007). However, hotlines that are not accredited may differ in whether suicide risk assessment procedures are completed and in thoroughness of the assessment, which can result in uneven quality of response across locations (Kalafat et. al., 2007). Although the Department of Mental Health requires each county's Mental Health Plan to operate a 24-hour, toll-free access line that provides information about accessing services and problem resolution processes, these lines may not include suicide prevention assessment and intervention.

The National Suicide Prevention Lifeline (800-273-TALK) is a 24-hour, toll-free hotline funded by SAMHSA. The National Lifeline consists of over 125 accredited call centers in 45 states around the country. When a caller accesses the Lifeline, the call is immediately routed to the closest affiliated call center. Callers can remain anonymous, minimizing concerns about stigma that may inhibit people in need from seeking mental health services elsewhere. To address the needs of callers who do not speak English as their primary language, the Lifeline operates a network of nine Spanish-language call centers across the nation, two of which are in California, and all Lifeline call centers have free access to a live language interpretation service that includes over 170 languages.

To become a member of the Lifeline, call centers must be accredited by an organization, such as the American Association of Suicidology, or licensed or certified by their county or state. This process ensures that responders are trained in evidence-based risk assessment procedures and that these procedures are consistently administered to all callers. The accreditation standards that the Lifeline accepts were developed with the involvement of national and international experts in suicide prevention to ensure incorporation of the latest research and information (Joiner et. al., 2007). Organizations applying for accreditation for the first time may receive technical support from the organization that will review the application. Once accredited, call centers can

apply for National Lifeline membership that includes a modest annual stipend, coverage of the phone line costs to calls placed to the Lifeline number, and ongoing technical assistance to ensure continuing, uniform quality across the network.

Currently, eight hotlines in California are members of the National Lifeline. Although anyone in California can call the Lifeline number, depending on their location they may not reach a call center in their area or even in the state.

Data from the National Lifeline indicate that in 2007, approximately 20 percent of calls originating in California were answered by hotlines in other states. California-generated calls that come from counties that do not have a Lifeline-accredited call center are routed to accredited call centers in other counties based on their availability and capacity (e.g., staff availability, busy lines, billing limitations). In a typical day, in addition to handling all the local calls in the Los Angeles area, the Didi Hirsch Community Mental Health Center takes calls from Santa Cruz, Fresno, Shasta, Sacramento, San Mateo, Kern, and Napa counties. When the Didi Hirsch Center cannot answer a call, such as when all its lines are busy, these California callers are served by a call center in Nebraska.

If calls are not answered locally, responders may not be able to refer individuals in crisis to local resources for follow-up care. California needs to increase the capacity of suicide prevention hotlines so that callers from every county can access a local, accredited call center. A long-term commitment to continuity and quality is needed to enhance the availability and capacity, including multiple-language capacity, of suicide prevention hotlines.

Hotlines have also been used to target prevention activities for specific populations. The San Francisco Institute on Aging Center for Elderly Suicide Prevention operates the Friendship Line; the line offers phone-based services, such as 24-hour crisis intervention and elder abuse prevention, as well as grief counseling, well-being checks, and information and referral services.

Several hotlines target youth. For example, the Trevor Project is a national crisis and suicide prevention hotline that focuses on lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. This service is provided 24 hours per day, seven days per week and is free and confidential. The Trevor Project also hosts a Web site with education resources such as training models and teaching guides, and an online forum that serves as a virtual warm line.

Finally, the VA and SAMHSA have collaborated to provide suicide prevention hotline services that are targeted to veterans. Individuals may now call the National Lifeline and choose a prompt to identify themselves as a veteran. They are immediately transferred to a hotline staffed by mental health professionals at

a VA facility in upstate New York, who will have information about VA resources throughout the nation.

### *Population-Specific Interventions*

Due to the unique characteristics of different age groups and ethnic populations, and the disparities of access to services they experience, effective approaches to suicide prevention need to include outreach and intervention strategies that target these specific groups (Pragmatic Considerations of Culture in Preventing Suicide, 2004; Luoma et. al., 2002).

*Older Adults*

Depression is the most significant risk factor for suicide in older adults, and it is also a condition that is often not recognized or treated (DHHS, n.d.). Frequently, signs of mental health problems are missed because they are mistaken as a normal part of aging, or they are misdiagnosed as cognitive impairments that are increasingly common with advanced age (Chapman and Perry, 2007, Bartels et. al., 2005; NIMH, 2003). Finally, stigma associated with mental illness may influence the likelihood of seeking mental health treatment (NIMH, 2003).

Although up to 75 percent of older adults visited their primary care physician within a month of their suicide, the majority of them were not receiving mental health treatment. Traditional mental health service systems are often not the most effective way to reach and serve older adults who may be at risk, and primary care services need to be improved.

Multiple evidence-based programs have been developed that target older adult mental health. Currently, ten programs are listed on the SAMHSA National Registry for Evidence-Based Programs and Practices (NREPP). Most of these programs contain components for outreach, engagement, and education that are embedded within existing community structures and services that older adults commonly use.

Other effective approaches integrate mental health services into primary care, such as co-locating health and mental health services. The Prevention of Suicide in Primary Care Elderly Collaborative Trial (PROSPECT) combines treatment guidelines for depression in primary care settings with comprehensive care management for older adults diagnosed with depression (NREPP). Trained clinicians work closely with the primary care provider, the older adult patient, and their family around treatment protocols and education. An outcome of this

program is statistically significant reductions in suicidal ideation (Bruce et. al., 2004).

IMPACT (Improving Mood--Promoting Access to Collaborative Treatment) is an intervention for patients 60 years or older who have major depression or dysthymic disorder (SAMHSA, NREPP). The intervention is a collaborative care approach in which a nurse, social worker, or psychologist works with the primary care provider, a depression care manager, and the patient to develop a multi-modal course of treatment that includes medications, exercise, identifying positive activities to engage in, and education about late life depression. IMPACT has been evaluated with racially, ethnically, and linguistically diverse older adults, including Whites, Latinos, and African Americans. Outcomes of this intervention include significant reductions in depression and improvements with work, family, and other social relationships. The IMPACT model has also been shown to be more cost effective than usual medical-based care for depression in older adults (Chapman and Perry, 2008).

There is also a need to address Medicare and insurance reimbursement issues that may create barriers to mental health services for older adults (Bartels, et. al. 2005; Karlin and Humphreys, 2007). The Program of All Inclusive Care for the Elderly (PACE) provides a model for coordinating Medicaid and Medicare financing with community-based social, mental health, and primary health services to provide an alternative to nursing home care (NREPP). An interdisciplinary treatment team oversees the implementation of the individualized treatment plan for each older adult enrolled in the program. Results from this program include decreased use of acute services, improved health and quality of life, and lower mortality rates.

*Survivors of Suicide Attempts and Suicide Loss*

Engaging those with direct experience of the impact of suicide, including families, friends, and survivors, can be a powerful tool to prevent suicide and future attempts. Many localities have support networks for people who have lost a loved one to suicide.

A growing body of literature substantiates the effectiveness of services and supports delivered by individuals with direct experience of mental illness, such as warm lines and peer-run support centers (Van Tosh and del Vecchio, 2000; DHHS, 1999). Organizations like the California Network of Mental Health Clients and the National Alliance on Mental Illness are important sources of support, advocacy, and information for mental health system clients and their family members. Many peer run organizations also provide support and advocacy for mental health clients who are transitioning out of homelessness, inpatient psychiatric hospitalization, or incarceration.

Recently, in response to the high rate of suicide in Humboldt County, the California Network of Mental Health Clients organized Suicide Alternatives Workshops that bring together survivors of suicide attempts, family and friends of those who have died of suicide, clergy, mental health clients, mental health professionals, and physicians. The workshops provided community education, outreach and peer support, and recommendations for a local suicide prevention plan.

Another promising practice is Web-based self-help, which is a cost effective approach to providing information and resources to those who have access to the Internet. Examples include the National Empowerment Center (www.power2u.org), a national consumer technical assistance center. Another example is "Beyond Blue," the national depression intervention initiative in Australia that hosts a Web site that offers self-assessment tools and resources to find mental health care, post notices on a bulletin board, and learn more about research (www.beyondblue.org).

Several programs have been developed that facilitate peer support among high-risk youth, many of which are school-based. The Trevor Project hosts an online peer support venue for lesbian, gay, bisexual, transgender, and questioning youth. Models for implementing a range of youth peer support programs are available on the Web site for SAMHSA's National Registry for Evidence-based Programs and Practices.

*Racial, Ethnic, and Cultural Communities*

The Surgeon General has reported significant disparities in access, availability, and quality of mental health treatment services for racial and ethnic minorities as compared to Whites (DHHS, 1999). These disparities are evident in the paucity of culturally and linguistically appropriate mental health services and supports, including inconsistency in language access in services, hotlines, and informational materials, and in the fact that many evidence-based practices have not been tested among diverse population groups.

Cultural differences matter substantially. African Americans are more likely to be incorrectly diagnosed than Whites and are also more likely to leave psychiatric treatment earlier (DHHS, 1999). This situation may be due in part to the possibility that African Americans may present their symptoms and respond to treatment differently from what most clinicians are trained to expect (1999). Furthermore, African Americans are substantially less likely than Whites to have access to treatment providers who are of the same race (1999). Fears of racism may exacerbate the problems of stigma and discrimination around mental illness.

Other cultural factors may adversely impact the mental health and suicide risk of immigrants and refugees, such as intergenerational conflicts related to acculturation, family pressures around academic achievement, and adverse experiences from the home country, including war, torture, and genocide.

California is a diverse state. Data from the 2000 Census indicated that the majority (53.3 percent) of California's population identified as non-White, and 40 percent spoke a language other than English at home (Lopez, 2002). A quarter of the population was born outside of the U.S., and the majority of Asians and almost half of Latinos are foreign born (Lopez, 2003). A combined 63 percent of these populations are concentrated in the San Francisco Bay Area and Los Angeles (2003). To address the needs of this diverse population, mental health and suicide prevention services need to identify and develop culturally appropriate approaches for successful outreach and engagement activities and effective diagnosis and treatment.

Promising strategies include engaging diverse communities through natural community leaders and helpers, such as faith leaders, community health workers (e.g., promotoras), or indigenous healers. If trained to recognize and respond to warning signs of mental illness and suicide risk, these individuals are in a position to promote early intervention for individuals at risk who may not otherwise seek professional help. A process of community engagement to determine the strategies used and to evaluate their effectiveness, for example, through community participatory action research methods, can increase the validity, acceptability, and sustainability of culturally appropriate mental health and suicide prevention practices within diverse communities (NIMH, 2004). Interventions need to be specific, targeted, and culturally relevant, including the role of families, faith communities, traditions, and other values and attitudes that include perspectives on suicide and mental illness (NIMH, 2004).

To address disproportionately high suicide rates in Native American communities, particularly among youth, inclusive approaches have been developed that involve the whole community. Although few evidence-based practices have been tested in Native American communities, tribes are actively engaged in developing and adapting best practices (Indian Health Service; One Sky Center, 2006).

For example, the Jicarilla Apache of Northern New Mexico developed a community intervention program involving tribal leadership, community members, youth, clinicians, university researchers, and the Indian Health Service that resulted in a 60 percent decline in suicides over a ten-year period (DHHS, 2005). Additionally, tribal programs in Phoenix and Alaska have implemented successful suicide prevention strategies that include training that incorporates not only

suicide prevention and intervention, but also culturally-specific, traditional approaches and perspectives (DHHS, 2005).

The Zuni Life Skills Development program is a school-based suicide prevention curriculum designed to reduce suicide risk and improve protective factors among Native American adolescents ages 14 to 19 years old (SAMHSA, NREPP). The curriculum includes topics such as building self-esteem, decreasing stress, increasing communication and problem-solving skills, recognizing and eliminating self-destructive behavior, learning about suicide, role-playing around suicide prevention, and setting personal and community goals. Lessons are interactive and incorporate situations and experiences relevant to Native American adolescent life. Most of the lessons include brief, scripted scenarios that provide a chance for students to employ problem solving and apply the suicide-related knowledge they have learned.

Lessons are taught by a team of teachers, community resource leaders, and representatives of local social services agencies to ensure that the lessons have a high degree of cultural and linguistic relevance. The Zuni Life Skills Development curriculum was developed with cultural components relevant to the people of the Zuni Pueblo in New Mexico and was tested and evaluated with that population. The Zuni curriculum served as the basis for the broader Life Skills Development curriculum that is now in use. The curriculum can be used with other Native American populations when implemented with appropriate and culturally specific modifications.

It is also important that mental health and health providers reflect the diversity of the population they are charged with serving, including language diversity, so that people of all cultures, ethnicities, and languages can feel comfortable seeking services that they are confident will appropriately and effectively address their needs. More research is needed about effective models and to test existing practices for their effectiveness among diverse populations.

*Children, Youth, and Young Adults*

It is important to promote protective factors against suicidal behavior in young people. A review of interventions by the CDC Task Force on Community Preventive Services (2005) reported that early childhood home visitation programs can prevent adverse outcomes, such as child abuse and neglect. Furthermore, therapeutic foster care reduces violence among chronically delinquent juveniles (CDC, 2005). This is an important outcome, since 25 percent of serious violent offenses in the U.S. are committed by youth between the ages of 10 and 17 years. This task force did not evaluate the impact of these programs on suicide. However, the approaches promote protective factors and

mitigate risk factors that can also lead to an increased risk of suicide in this vulnerable population.

Because school is where many youth spend a large part of their days, school staff are in the position to detect the early stages of mental health problems and potential suicide risk. By 2000, 77 percent of schools in the United States had implemented a suicide prevention program (Brener et. al, 2001; Small et. al., 1995 as cited in Kataoka et. al., 2007). Some programs use early intervention strategies, such as screening instruments that detect warning signs of self-harm and suicidality (Kataoka et. al., 2007; Jamison, 1999). School-based programs can be successful in encouraging students at risk who might not otherwise seek help and providing or linking them to mental health services. The programs can also be successful in developing protocols to handle a suicide crisis that minimizes the chances of a contagion effect[10].

School programs can enhance the capacity to build resiliency among students by adopting curricula that teach problem-solving skills, conflict resolution, and nonviolent handling of disputes. This approach may be particularly important for adolescents and youth who are coping with the stigma and prejudice associated with exploration of sexual orientation and gender identity. One study found that heterosexual students reported higher levels of protective factors, such as family connectedness, adult caring and involvement, and feeling that the school was a safe place, than homosexual students (Eisenberg and Resnick, 2006).

Unfortunately, many young people who are at high risk of suicide may have already stopped attending school or may have contact with the juvenile justice system. It is critical to develop strategies to reach out to these individuals through community groups and places where young people congregate. It is also important to train the program staff who provide services to at-risk youth to ensure they are able to recognize the warning signs of suicide and how to intervene early.

Nationally, many more children and youth need specialized mental health services than actually have access to them (Stroul, 2007). Several strategies have been recommended to improve service delivery and training of providers, particularly in primary care, who routinely come into contact with adolescents and youth who may be at heightened risk of emotional disorders or suicidal behavior. Examples are co-location and training of child mental health specialists to work in primary care settings, and enhanced training in medical school and for providers in practice (Stroul, 2007).

[10] Contagion effect: phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

The tragic events at Virginia Tech raised national awareness of the need for earlier and better comprehensive mental health services on college campuses. Some of the key findings of the *Report to the President on Issues Raised by the Virginia Tech Tragedy* (2007) included:

- Sharing critical information among education officials, health care providers, law enforcement personnel, and others facing substantial obstacles because of confusion about confidentiality laws.
- Parents, students, and teachers need to learn to recognize warning signs and encourage those who need help to seek it.
- Effective coordination of providers who are sensitive to the issues of safety, privacy, and provision of care is needed to ensure that people with mental illness are integrated into the community.
- Full implementation of emergency preparedness and violence prevention plans is needed to address school and community violence.

SAMHSA has launched a suicide prevention initiative that targets adolescents and youth. The Campus Suicide Prevention Grant Program provides funds to assist colleges and universities in their efforts to prevent suicide attempts and completions and to enhance services for students with mental health problems, such as depression and substance abuse, that put them at risk for suicide and suicide attempts. Program requirements include providing suicide prevention training and education programs for students and campus personnel, enhancing the network of campus mental health services to include the broader community where needed, developing campus-based hotlines or linking hotlines with the National Lifeline, and disseminating materials to the campus community as well as families to educate them about the warning signs of suicide and to counter stigma and encourage help-seeking behaviors.

In addition, the State/Tribal Youth Suicide Prevention Grant Program provides funds to states or tribes to develop a public/private coalition among youth-serving institutions and agencies, including schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth-supporting organizations. This coalition is responsible for implementing a youth suicide prevention plan that includes enhanced assessment, early intervention, and treatment for at-risk youth.

Increasing the availability of mental health and suicide prevention services on college campuses is an important step in preventing suicide among young adults. Reports from the California Department of Education and the UC Regents, among others, have recommended implementation of strategies to achieve this step (California Department of Education, 2005; University of California, 2006). However, a suicide prevention system for young people must include strategies that start much earlier than the presentation of suicidal ideation.

*Correctional Facilities and Law Enforcement*

Many effective programs offer models for partnership between the criminal justice and mental health systems, for example jail diversion and re-entry programs. By building local partnerships between and within the criminal justice system and at the community level, suicide risk among inmates can be reduced along with the medical cost of treating acute problems, which will provide a safer setting for inmates as well as staff (American Association of Suicidology; National Conference of State Legislatures, 2007).

To address the mental health needs and suicide risk of individuals who were being released from jail, were identified by the courts as repeat offenders, or were being discharged from an inpatient psychiatric facility, one community in Monroe County, New York, developed a coalition of community care providers, the county mental health department, local criminal justice systems, the courts, and the university psychiatry department to reach out to these individuals and provide coordinated services. Individuals in the program received intensive case management, evaluation of medical and mental health problems, supervised housing, and other services. Outcomes of this project included no suicide attempts, assaults, or other reportable incidents during the study period among subjects, and the reduction in jail and hospital expenses amounted to approximately three times the program's cost (American Association of Suicidology, 2003). The findings from research and data on the needs of this population provide strong support for implementing programs in jails and prisons as well as programs that support re-entry into the community.

California's prison system paroles over 100,000 inmates every year (California Department of Corrections and Rehabilitation). Many of these inmates will require community services to maintain their health, mental health, and well-being after release. Recently, the California Legislature has required the Department of Corrections and Rehabilitation and community agencies to work together to provide better re-entry programs and services for parolees. Collaboration between the prison system, community social services, and the community mental health system is necessary to support this effort to provide continuity of care, particularly as California's prison system continues to shift toward a recovery and rehabilitation model for inmates with severe mental illnesses.

*Employers*

Integrating suicide prevention into work settings is recommended to reach a large number of adults who may be at risk, but who are not currently utilizing or likely to seek out mental health services. Resources need to be developed and

disseminated to employers that provide guidance about how to recognize and assist employees who may be exhibiting warning signs of suicidal behaviors, who are coping with family members or friends of individuals presenting with suicidal behaviors, or who are themselves survivors of suicide. Recently, the Partnership for Workplace Mental Health, which includes the American Psychiatric Association, the American Psychiatric Foundation, and business leaders, launched *Employer Innovations Online* (www.workplacementalhealth.org). This searchable online data base provides resources, models, assessment tools, and detailed information for employers to develop strategies to address workplace mental health issues (American Psychiatric Association, 2008). Another resource is the National Business Group on Health, an organization that provides information and resources on health and mental health issues in the workplace (SAMHSA, 2007).

Employers should be encouraged to access these resources as well as to build and maintain a directory of local prevention, treatment, and support services and make them readily available, in a non-stigmatizing manner, to all employees. Another approach is to build outreach and education about suicide prevention and mental health into existing support networks, such as employee assistance programs, to reach people who might not otherwise seek help.

*Veterans and the Military*

Given the magnitude of the problem of suicide among veterans, it is critical that the military and the reserves are partners in implementing the California Strategic Plan for Suicide Prevention, including the California National Guard and the VA medical centers in the state.

Active military and veterans are at disproportionately high risk of mental illnesses, PTSD, and suicide (Hoge et al., 2004; Department of Veterans Affairs, 2007). Strategies to address suicide prevention among veterans must take into account the prevalence and characteristics of stigma and fears of discrimination in the military that constitute barriers to needed care. Strategies must also address access to mental health services, especially for veterans who may live far away from a VA Health Center. The increasing volume of need for mental health services among the thousands of veterans returning from Iraq and Afghanistan must also be met. Although the VA has been working to increase the availability of counseling services for veterans, the number of new hires for VA-operated community-based health centers around the nation (Steverman, 2007) will not sufficiently fill the gaps.

Beginning in fall 2003, the Army convened Mental Health Advisory Teams (MHAT) to annually review data on mental illness and suicide among deployed soldiers, assess quality and access to mental health care, and provide

recommendations for improvements (U.S. Department of the Army, 2006). Recommendations from early MHAT reports led to the Army Suicide Event Report, a reporting and tracking mechanism that collects extensive data about suicides and attempts (2006). The development of the VA Suicide Prevention Lifeline is another step toward addressing veterans' specific and urgent mental health needs.

**Multi-Level Public Health Approach**

The Air Force Suicide Prevention Program is an evidence-based practice that was developed in response to a rise in the suicide rates of in the Air Force in the early 1990s (DHHS, 2002). The program uses a multi-level intervention targeted at reducing risk factors and enhancing protective factors, including reducing stigma around seeking help, promoting education about mental health, changing policies, and shifting social norms. Eleven initiatives were implemented, including:

- Strong messaging from the Air Force Chief of Staff that promotes social support between officers, supervisors, and coworkers and the value of seeking mental health services early
- Educating community members by requiring personnel to receive suicide prevention training, and encouraging each Air Force installation to develop "home grown" training programs that reflect its local community
- Improving surveillance through an online database that collects demographic, risk factor, and protective factor data; and developing a Behavioral Health Survey that provides unit-specific feedback to commanders to help tailor intervention to each community
- Developing critical incident stress management teams at each installation to respond to units that are impacted by events such as deployments, natural disasters, and other potentially traumatizing events
- Integrated service delivery at each location to ensure that chapel programs, mental health services, family support centers, child and youth programs, family advocacy programs, and health and wellness centers are available and coordinated for each base location

The program resulted in significant increases in Air Force personnel that were trained in suicide prevention and educated about violence prevention (Knox et. al., 2003). After implementation of the program, there were significant reductions in suicides, homicides, accidental deaths, and moderate and severe family violence (Knox et. al., 2003). The success of this model indicates that systemic interventions that change social norms about seeking help from being a sign of weakness to a sign of strength, and institutionalization of training about suicide prevention can have substantial impact on promoting mental health and reducing a range of adverse outcomes.

The universal, multi-layered strategy exemplified by the Air Force Suicide Prevention program is a good example of an approach that has been used to successfully address other public health problems, such as reducing cardiovascular disease (Knox et. al., 2004). Efforts to address the broader, modifiable risk factors that predispose individuals to heart disease were developed in parallel with technological advances that improved outcomes for people who have already developed the disease. Along with activities such as education about recognizing the warning signs of a heart attack, widespread training in cardiopulmonary resuscitation, and the development of new medicines were strategies that educated the public about the benefits of a healthy lifestyle and of reducing or eliminating behaviors that contribute to long term risk. Changes in public policy, such as laws related to smoking, supported this shift in cultural and social norms that has reduced the risk of a range of diseases.

There is a difference between the traditional, clinical-based approach to suicide prevention and the public health approach that was employed by the Air Force Suicide Prevention program (Knox et. al., 2004). The clinical approach rests on identifying and treating individual risk factors when evidence of disease is present. Typical suicide prevention strategies have focused largely on recognizing warning signs and individual-level risk factors rather than considering the important role of population-level mental health promotion with all individuals on a continuum of risk. Interventions are broad, multi-layered, and occur both well before a problem arises as well as at various phases after it is present. The Air Force Suicide Prevention program demonstrates that when a public health approach is applied to the problem of suicide and a broad range of prevention and early intervention strategies are put into place, the likelihood of multiple negative outcomes, including suicide, mental illness, and violence, are all reduced.

## Implementing Training and Workforce Enhancements

Effective suicide prevention strategies depend on a trained workforce and an educated public. It is imperative to ensure that providers in multiple service fields are equipped to recognize and intervene when suicide risk is present. Training and service guidelines need to be implemented, targeting the specific concerns and opportunities for intervention that are present in different settings, including primary care, mental health clinics, classrooms, juvenile justice facilities, substance abuse treatment programs, older adult and long term care programs, and the venues served by law enforcement and probation officers

*Establishing Guidelines for Professionals*

A substantial precedent exists for establishing guidelines for training and service in selected occupations. For example, the American Psychiatric Association has developed guidelines for mental health professionals, and the SPRC has developed a curriculum for suicide prevention programs within law enforcement departments.

*Youth Suicide-Prevention Guidelines for California Schools* (2005) assists schools in developing and implementing plans for youth suicide prevention, intervention, and aftermath. SAMHSA and the SPRC have developed materials that support the development of guidelines in campus settings. For example, *Promoting Mental Health and Preventing Suicide in College and University Settings* (SPRC, 2004) provides recommendations for institutions of higher education to assist with the implementation of suicide prevention programs.

Finally, SAMHSA and the American Association for Suicidology have developed guidelines for developing discharge protocols for use in emergency departments and providing follow-up care for individuals who have attempted suicide (Deisenhammer et. al., 2007; DHHS, 2001).

*Health, Mental Health, and Social Services*

Health clinics, i.e., primary care and prenatal care, mental health centers, emergency response systems, crisis centers, and alcohol and drug programs, are key access points. Personnel in these systems need to have consistent guidelines for effective assessment and treatment interventions.

Unfortunately, there are many missed opportunities for prevention and early intervention among people who are at risk of suicide. Improved training guidelines and service protocols will better prepare providers to appropriately respond when suicide risk is present. Equally critical is the need to assess for mental health conditions that are associated with significant increase in suicide risk, such as depression. Routine screening has been shown to be effective in identifying and successfully treating depression in specific populations that are at higher risk of suicide (Georgiopoulos et. al., 2001; DHHS, n.d.). It is important that screening be accompanied by policies ensuring confidentiality and protection from discrimination along with the availability and accessibility of appropriate, quality, follow-up services.

In one study of physician visits by patients presenting with either major depression or an adjustment disorder, physicians asked questions about suicide in only 36 percent of visits (Feldman et. al., 2007). Physicians were more likely to ask questions about suicide if they had personal experience with depression or if the patient prompted the discussion (2007). Health providers may be reluctant to ask questions about suicide risk if they do not feel adequately trained in

suicide assessment and treatment, or if they do not know how to refer patients to a mental health provider who can provide these services (Feldman et. al., 2007). Educating health professionals to recognize and treat depression and other conditions that present a heightened risk of suicide, and providing them with the tools to consistently and properly address suicide can prevent suicide deaths (Feldman et. al., 2007; Mann et. al., 2005).

A survey of over 300 emergency departments in California found that most rely on external mental health professionals, such as mobile crisis, private psychiatric evaluation teams, or social workers to provide suicide assessments and referrals (Baraff et. al., 2006). Yet mental health professionals in California do not have a standard competency or licensing requirement that specifically focuses on assessing, treating, and caring for patients at risk for suicide. The majority of respondents identified a need for increased access to mental health professionals to be able to adequately help individuals who enter emergency departments in mental health or suicide crises.

Medical professionals who treat older adults, staff working in older adult services, long-term care, and adult protective services programs, should be trained to recognize signs and risk factors of suicide in older adults. Depression is a significant risk factor of suicide in older adults; therefore, staff in these programs must be able to recognize the signs and symptoms of geriatric depression.

Staff working in social services, child protection, foster care, and juvenile justice interact daily with high-risk youth and are in a critical position to identify and intervene when adverse childhood experiences have taken place or suicidal ideation and behavior are present. To appropriately identify and reduce suicidal behavior, staff in these systems need to be trained in prevention and early intervention strategies that are effective for the populations they serve.

*Law Enforcement*

Law enforcement officers are often the first on the scene when a suicide crisis emerges; they also come into contact with family members and loved ones of individuals who have died by suicide. Several evidence-based training models exist that educate officers about the signs of mental health problems and suicide risk and how to appropriately intervene while maintaining public safety (Lyons, 2007). For example, the Crisis Intervention Team (CIT) provides officers with training that includes a simple eight-question assessment tool, along with techniques for de-escalating a crisis. CIT has been implemented in many locations nationwide. Many local law enforcement agencies report that it is even more effective than a traditional mobile crisis response because police are typically first responders who are on the scene within 10 to 15 minutes (Reuland,

2004). CIT has also been shown to reduce officer injury rates five-fold (Dupont et. al., 2000).

## Educating the Public to Take Action to Prevent Suicide

*Educating Community Gatekeepers*

Many suicide prevention strategies seek to encourage help-seeking behavior. The intent of this strategy is to encourage individuals to learn that it is acceptable to acknowledge a problem and that help is available. Factors such as personal or cultural beliefs about mental illness, suicide, and asking for help; concerns about stigma and discrimination and fears of repercussions; and a belief that nothing can help or that no one cares can dissuade people from seeking help. Strategies that promote help-seeking behavior encourage people to reach out to family, friends, and resources in their communities when they are in need. These resources may include mental health services, peer support groups, community helpers such as promotoras, and faith-based organizations.

Gatekeepers are defined as those who regularly come in contact with individuals who may be contemplating suicide. Gatekeeper models provide education and training in identifying the warning signs of mental health problems and suicide risk and how to refer people to services that can help. The gatekeeper model is an effective strategy for reaching high-risk individuals who may not otherwise seek mental health services and supports or whose risk factors may not be visible to health and mental health professionals.

Gatekeeper training targets a broad range of people in the community. The following is a list of possible community gatekeepers, including those identified in the National Strategy for Suicide Prevention (DHHS, 2001):

- School health personnel
- Employers and supervisors
- Clergy and faith-based community leaders
- Natural community helpers, such as promotoras, senior center staff and volunteers, and staff from cultural resource centers
- Personnel and volunteers in older adult services and long-term care, including home health care, adult protective services, in-home support services, congregate or home delivered meals, and caregiver support services
- Hospice and nursing home staff and volunteers
- Personnel in group homes and licensed care facilities
- Emergency health care personnel, including first responders

The above list is general; training strategies should consider the target population and ensure that individuals most likely to interact with those at risk in the community are included in the planning process.

*Reducing Access to Lethal Means*

Reducing access to lethal means is an important component of suicide prevention when it is integrated with other local, regional, and state-level activities that take into account target populations and consideration of methods that are frequently used in a particular locality (Beautrais, 2007). Having a gun in the house is associated with higher risk of suicide among both adults and adolescents, and regions of the country with high rates of gun ownership also have higher overall suicide rates (Miller et. al., 2007; Grossman et. al., 2005). Using gun storage safety precautions, such as gun locks, storing guns unloaded and storing ammunition in a separate, locked container, are associated with lower numbers of both suicide deaths as well as unintentional injuries (Grossman et. al., 2005). Studies show that more restrictive firearm legislation, such as Child Access Prevention laws, has led to a significant decrease in suicide rates (Kapusta et. al., 2007; Webster et. al., 2004). Public policies that restrict access to lethal means and educate people about how to safely handle potentially lethal materials – from firearms to medications – can save lives.

Information from the SPRC indicates that multiple efforts are under way in other states to address access to lethal means. Maine, New Hampshire, and Oregon provide educational materials and training about screening for access to lethal means in potentially suicidal patients who are in a primary care or emergency department setting, and how to provide counsel about reducing access to lethal means. Montana and Wyoming distribute free gun locks at community events.

There are examples of how reducing access to lethal means can reduce the rate of suicide (Daigle, 2005). In the early 1960's England detoxified domestic gas; after this, the overall suicide rate declined by one-third. Installation of a barrier on the Duke Ellington Bridge in Washington, DC led to a reduction in the overall suicide rate in the city despite the presence of an equally high bridge one block away. National changes in firearms laws in Canada were followed by a reduction in suicide by firearms, particularly among youth; however, rates among older men, who are most likely to own guns, were not changed, and use of other methods by youths increased.

Most suicides by jumping occur from high-rise residential buildings (Beautrais, 2007). However, in certain locations an iconic structure may attract suicide attempts, which may develop in part from media coverage about suicides from these structures as well as romanticized ideas about what it is like to die by that method or symbolism behind that means of death.

Barriers designed to prevent suicide by jumping, such as the safety railings that have been erected on the Eiffel Tower and the Empire State Building, are effective in reducing or eliminating suicides at those sites. One of the challenges is that, due to relatively low numbers of suicides by jumping compared to other methods and the question of substitution, it is unclear if barriers would impact the overall suicide rate. This issue has been the source of considerable local controversy in areas where bridge suicides are a problem. Barriers can be controversial due to their cost relative to number of lives lost, aesthetics, and perceptions about the inevitability of someone completing suicide another way if they are prevented from doing so by a barrier. A 30-year old study of 515 individuals who were restrained from attempting suicide from the Golden Gate Bridge concluded that approximately 90 percent of them did not subsequently die by suicide or other violent means, suggesting that when suicide is deterred, the vast majority of individuals did not substitute another method (Seiden, 1975).

The Marin County Coroner's Office reports that in the 10-year period between July 1997 and June 2007, there were 206 suicide deaths from the Golden Gate Bridge. Over 90 percent of the individuals that died were from Northern California, and half were from four of the six counties that are within the Golden Gate Bridge District (Marin, Napa, Sonoma, and San Francisco). It is estimated that approximately 1,200 people have lost their lives by jumping from the Bridge since it opened in 1937. In response, the Golden Gate Bridge, Highway and Transportation District (the District) has implemented several strategies to reduce the number of suicides. These include 11 emergency/crisis counseling telephones along the sidewalks, surveillance cameras, and training bridge patrollers to detect persons exhibiting suicidal behaviors. The District estimates that these strategies helped deter approximately 70 percent of suicide attempts. Currently, the District is completing an environmental study to develop and evaluate options for a physical suicide deterrent system (such as higher railings or a barrier) for the bridge. The study will be available for public comment in summer 2008.

*Public Awareness Campaigns, the Media, and the Entertainment Industry*

Stigma around mental health is a deeply engrained part of our culture. Negative portrayals of individuals with mental illness and sensational coverage of a tragic event contribute to stigmatizing attitudes in the general public, which often lead to discrimination. Unfortunately, these depictions of people with mental health problems as unpredictable and even dangerous are common in films, television, and the news media. When not countered with education and awareness about the facts of mental illness, these stories fuel people's fears and promote self-stigma among individuals with a mental illness diagnosis (SAMHSA).

Discrimination is evident in policy decisions ranging from health insurance coverage and employment to research priorities (Jamison, 2006).

Nearly two-thirds of those who have a diagnosable mental illness do not seek treatment because of fears of stigma and discrimination (DHHS, 1999). SAMHSA has launched an ongoing anti-stigma campaign that offers resources to states to develop their own targeted anti-stigma materials. Localized stigma and discrimination reduction projects are also under way in California through Mental Health Services Act funding. Development of a statewide suicide prevention campaign should complement local and national anti-stigma campaigns, peer-to-peer programs, and personal contact strategies that effectively increase awareness of suicide and how to find help (National Mental Health Awareness Campaign, 2006).

There is a need for education about the warning signs of suicide with a clear and consistent message about how to respond to suicidal behaviors, tailoring that message to include population-specific risk factors where appropriate. Such activities include designing messages that educate the public that suicide is preventable, raising awareness of the populations at risk, forging new and creative approaches to engage community partners, and promoting community-based support systems and cultural-specific ways of healing. Use of multiple media channels, including the ethnic media, is necessary to ensure that the message is far reaching. Linking with national campaigns, such as National Suicide Prevention and Awareness Week and National Depression Screening Day, should also be considered to maximize impact and exposure by reinforcing the messaging.

Public health has successfully used statewide social marketing campaigns to promote public awareness and to influence health behaviors on various topics. The California Tobacco Control Program (CTCP) was formed after Proposition 99 passed in 1988, providing California with the funds to initiate a comprehensive anti-tobacco program. The CTCP found that the most efficient way to reach its goal of decreasing tobacco-related deaths and disease is to implement initiatives statewide that seek to change social norms that influence individual behaviors (CDPH, 2006). The CTCP uses an approach of countering negative influences by depicting tobacco use as undesirable and socially unacceptable (CDHS, 2006). The campaign also supports smoking cessation efforts through a helpline and community-based programs. Finally, the campaign includes a media education component to offset depictions of smoking as acceptable in movies and to counter tobacco industry advertising. Some of the results of the program include an increased desire and intention to quit among smokers, and the smoking prevalence in the state has declined by 33.6 percent since the program's inception (CDPH, 2006).

Research indicates that exposure to suicide through the media may increase the risk of suicide, a phenomenon called “contagion” (DHHS, 2001). When the number of stories about suicides increases, or a death is reported at length or featured prominently, the contagion effect can lead to an increase in suicides (Hassan 1995; Phillips et. al., 1992). Guidelines to inform the media can impact the decisions reporters make about how to cover suicide incidents in a way that balances public safety with what is newsworthy (American Association of Suicidology; Pirkis et. al., 2007). Media coverage should be used as a positive tool to promote greater understanding of the risks and protective factors and how to get help.

National and state public health agencies have developed mechanisms to engage and educate engage and educate the entertainment industry around health promotion and disease prevention. For example, Hollywood, Health & Society is a Norman Lear Center project that provides the entertainment industry with accurate and timely information for health storylines. The project is funded by the CDC, the National Cancer Institute (NCI), the Agency for Healthcare Research and Quality (AHRQ), the Health Resources Services Administration, and the California Department of Health Services. According to a 2001 survey, over half of regular television viewers reported that they learned about a disease or how to prevent it from a TV show, and about one-third of regular viewers said they took some action after hearing about a health issue or disease on a TV show. Finally, SAMHSA has begun to engage the entertainment industry via the VOICE Awards, an annual event that honors the TV and movie industry for positive, recovery-oriented portrayals of mental illness.

## Improving Program Effectiveness and System Accountability

*Surveillance, Research, and Evaluation*

Existing local and state data on suicide provide an incomplete picture of the true magnitude of the problem in California. Due to the paucity of disaggregated data, there are gaps in knowledge about how suicide impacts certain racial and ethnic groups. While information is available about a number of effective and promising suicide prevention practices, much more needs to be learned about programs specifically designed to serve certain population groups. With these substantial gaps in knowledge about how suicide impacts Californians and how to better prevent it, a research agenda must be established to better design responsive policies and effective programs towards reducing the impact of suicide.

California is a large, diverse state with unique demographics. To strengthen suicide prevention, there is a need to increase knowledge about the causes and types of suicide, the stages of suicidal behaviors (e.g., ideation, planning,

attempt, and aftermath), and the impact of exposure to trauma, such as adverse childhood events, historical trauma,[11] intergenerational conflicts,[12] and trauma history within an immigrant's country of origin. Understanding the role of multiculturalism and acculturation in the development of risk and protective factors in immigrant communities should be enhanced. More information is also needed about the relationship between suicide and postpartum depression, homicide, and other factors. We need to know more about risk and protective factors based on gender, age, disability, sexual orientation, homelessness, rural location, military services, and other factors related to identity.

To increase knowledge on these issues, California needs to expand its capacity for surveillance, research, and evaluation on suicide and suicide prevention. Surveillance is the continuous collection of information on the entire population for the purposes of monitoring and describing a problem. Research refers to limited, focused efforts to answer specific questions that cannot be answered easily through surveillance alone. Evaluation aims to determine how best to design and improve programs. These three approaches often overlap and interact, and all are necessary to support effective policies and programs.

Fortunately, California has the necessary partners and elements to take on this work. Multiple state agency databases exist that can be coordinated, connected, and enhanced to fill gaps in knowledge. California hosts a wealth of world-class research universities and institutes. Existing statewide surveys can be expanded to provide a broader picture of suicidal behavior. These surveys include the California Healthy Kids Survey for middle and high schools, the California Behavioral Risk Factor Surveillance and Youth Risk Behavior Surveillance instruments, the California Health Interview Survey, and others.

Accurate and complete information, including disaggregated racial and ethnic data, about suicide prevalence and prevention need to be widely accessible to the public and to policymakers to inform service and system improvements. Nationally, one persistent challenge is that the information that flows into reporting systems may not be uniform and may come from different places. For example, the death certificate may ultimately be completed and signed by medical examiners or coroners, or by a public official in the legal system, which may result in differences in how suicide deaths are determined and recorded (Goldsmith, 2001). One solution to this inconsistency is a single set of criteria for identifying and reporting suicide deaths that is widely used by both medical and legal systems. Another is to explore ways to expand or link the data systems that already exist, such as vital statistics; coroner records; hospital files; crisis

[11] Historical trauma is the collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide.
[12] Intergenerational conflicts occur between generations and are related to the acculturation process of immigrant families.

centers; mental health, alcohol and drug programs; corrections; and school districts.

An example of how data system linkage can increase knowledge about suicide is the CDC's National Violent Death Reporting System (NVDRS). California is one of 17 states currently participating. The California NVDRS links data from death certificates, police reports, and medical examiner or coroner reports to provide a better understanding of the incidents and risks of violent deaths, including suicide. Information from this database is used to identify trends and risk factors that can inform program and policy decisions to more effectively prevent suicide. NVDRS is also used to identify additional information that needs to be collected to pinpoint the factors associated with suicide. This database is scheduled to be available online in spring 2008. Some examples of how states have used the NVDRS include the following:

- Maryland changed its mental health outreach strategies when it learned that men have much higher rates of suicide and lower rates of contact with the mental health system than women.
- South Carolina instituted new screening protocols when it found that two-thirds of youths who committed suicide were involved in the juvenile justice system.
- Oregon now helps medical professionals identify patients at risk in response to findings that 37 percent of older adults visited a physician in the month prior to their death.
- Rhode Island now gathers information on specialties of physicians prescribing drugs, because data from its reporting system suggested that inadequate drug counseling may be implicated in suicide by overdose.
- California's use of the NVDRS has documented that the following risk factors were present in eight out of ten suicide deaths in three Bay Area counties, providing a basis for prevention planning:
    - 60 percent had a mental illness.
    - 30 percent documented a role of physical health problems.
    - 25 percent had made previous attempts or had spoken about their intent.
    - 25 percent reported problems with substance abuse.
    - 21 percent were having interpersonal problems with their partner or another individual.
    - Smaller percentages involved issues with employment, finances, and deaths in the family.

Efforts to expand statewide data systems should be complemented by strategies to increase local capacity for data collection, surveillance reporting, and information dissemination. As critical local partners in reporting on suicide deaths, coroners and medical examiners should be engaged in this process.

It is important to explore innovative and community-based research methods. For example, community participatory action research represents a true collaboration between researchers and the communities that are impacted by the research. Communities are integrally involved in identifying research questions, methods, and defining outcomes that are relevant to the community. Other research methods including longitudinal studies, qualitative studies such as focus groups, ethnography, and oral histories, are also important methods that can be developed to clarify how we can improve suicide prevention strategies tailored to local problems.

One promising model is case review teams, which provide a mechanism for communication and collaboration between different service systems that have important roles in a case. Child death review teams address concerns about the underreporting of child homicides by bringing together a multidisciplinary group that includes medical examiners and coroners to determine cause of death and improve surveillance (Durfee et. al., 2002).

In California all 58 counties have a child death review team. The purpose of these teams is to prevent child abuse and neglect by understanding the factors that contribute to each death and translating the learning into effective policies. Local teams are supported by a state team that oversees local activities, analyzes standardized local data into an annual report, and provides training on important confidentiality, procedural, and technical issues.

Some examples of policies that have changed as the result of child death review teams involve pool fencing and zero tolerance for guns on school property. Several counties have expanded the local child death review team into programs that also offer services and public education around issues such as bereavement, critical incident debriefing, and Sudden Infant Death Syndrome.

Currently, 25 counties also have a Domestic Violence Fatality Review team. These local teams are supported through a partnership between the California Health and Human Services Agency and the District Attorney's Office. In 2000 a statewide advisory committee developed a Review Team protocol and also hosts regional trainings for local death review team participants. Outcomes of this effort include a Risk Assessment Checklist for court judges and a database that tracks risk factors associated with domestic violence-related fatalities.

Counties may have other death review teams related to specific settings, such as deaths of individuals under treatment with the public mental health authority and hospitals.

In San Francisco the recognition that 70 percent of suicide deaths were from traumatic self-injury (i.e., versus poisoning), along with the fact that two-thirds of those who died by suicide were in psychiatric treatment at the time of their death, led to the implementation of joint psychiatric and trauma service review teams at San Francisco General Hospital (NVDRS and Suicide, SPRC Fact Sheet; Schecter et. al., 2005). Suicide review teams created a feedback mechanism between different systems to improve care and ultimately prevent suicides in the city.

Finally, there is a need to identify and disseminate models for evaluating suicide prevention programs and activities to increase the number of evidence-based programs in California. This need includes collecting outcome measures that are consistent and relevant to improve programs and the experiences of service users. Culturally and linguistically appropriate approaches to suicide prevention need to be strengthened. Alongside statewide stigma reduction efforts, there should be an evaluation of how social norms change and their effects on rates of suicidal behavior and appropriate help-seeking.

Several resources support the dissemination of evidence-based suicide prevention practices, such as the SPRC's Best Practices Registry and NREPP. The criteria required for inclusion in these registries (i.e., proven, promising, and emerging) are reliable sources of information about the practice, including whether it has been tested in diverse population groups.

# Part 3: Strategic Directions and Recommended Actions

The Suicide Prevention Plan Advisory Committee formulated four strategic directions and corresponding recommended actions to set the course for reducing suicides and suicidal behaviors in California. These recommendations are grounded in the data and evidence offered in the two preceding chapters and were refined through the course of many rich discussions by the committee.

The *California Strategic Plan on Suicide Prevention* serves as a platform for developing and offering a comprehensive range of strategies, starting from prevention and early intervention to crisis services and aftercare, for children and youth to adults and older adults from diverse backgrounds. The programs and services generated from this plan must go beyond traditional approaches that solely depend upon identifying and treating individual risk factors. A population-based approach is essential and will require community-wide strategies and responsive organizational and environmental policies and practices. State and local partners spanning multiple disciplines and settings must work together to create the coordinated system of suicide prevention that is needed to make a difference in California. Lastly, ongoing research and evaluation must be viewed as a keystone element to continuously review and assess the efforts and overall direction. The Plan represents the initial five-year phase of this process.

It is fortuitous that this Plan is being released when there is a concerted effort underway through the Mental Health Services Act to focus more on health, wellness, resiliency and recovery, and to reduce stigma associated with mental illness. With so many lives at stake, the time is now to make suicide prevention a priority.

## About Strategic Directions and Recommended Actions

The Pplan is organized by two levels of focus for suicide prevention: strategic directions and recommended actions.

Strategic directions are grouped into four areas to structure the work:

1. Create a system of suicide prevention.
2. Implement training and workforce enhancements to prevent suicide.
3. Educate communities to take action to prevent suicide.
4. Improve suicide prevention program effectiveness and system accountability.

Strategic directions are broad levels of focus that serve as the central aim that the more specific recommended actions address. These recommended actions

are not an exhaustive list, but they emerged as priorities at this point in time to reduce suicide and its tragic consequences on individuals, families, and communities throughout California.

Taken together, the strategic directions and recommended actions are intended to lay a foundation for a comprehensive system of suicide prevention that builds on existing infrastructure, expands capacity of co-existing systems, and identifies and fills gaps in services and programs.

The following **six core principles** are embedded in all levels of planning, service delivery, and evaluation:

**Core Principle 1. Implement culturally competent strategies and programs that reduce disparities.**

To be effective, systems, organizations, and services for suicide prevention must embrace behaviors, attitudes, and policies that are compatible with diverse belief systems and customs. A key goal is to reduce disparities in the availability, accessibility, and quality of services for racial, ethnic, and cultural groups that have been historically underserved. Planning and service improvement processes should involve members of the targeted racial, ethnic, and cultural groups.

**Core Principle 2. Eliminate barriers and increase outreach and access to services.**

Potential barriers must be addressed in designing and implementing outreach and service programs to ensure improved access for all Californians of diverse backgrounds and abilities. People who live in rural areas often must travel significant distances to access needed services. Many other individuals are isolated by physical and/or psychiatric disabilities, including age-related disabilities that render them homebound or marginalized from needed support systems. Information, programs, and materials need to be accessible and available in a variety of languages and formats. Programs and services must be accessible to those for whom English is not the primary language; with low literacy skills; and with vision, hearing, and cognitive impairments.

**Core Principle 3. Meaningfully involve survivors of suicide attempts; the family members, friends, and caregivers of those who have completed or attempted suicide; and representatives of target populations.**

Those who have survived a suicide attempt and their family members, friends, or caregivers bring important personal experience and unique perspectives to identifying service needs and gaps in the system and to delivering services.

Additionally, when service improvements are under way that target specific populations, representatives of these groups must be involved in all aspects of planning and implementation. Peer support and education are invaluable components of a comprehensive system for suicide prevention.

**Core Principle 4. Use evidence-based models and promising practices to strengthen program effectiveness.**

Many existing programs and practices have demonstrated effectiveness, broadly or within specific populations. Attention should be given to replicating and disseminating or adapting these effective program models and promising practices. Program design should include consideration of how evaluation can be used as a management tool to strengthen and improve programs. Evaluation data can be an invaluable tool to garner support for program implementation at all levels.

Many programs and providers currently offer needed and effective services to prevent suicide. Where such promising service or program models exist, the focus should be on coordinating and building upon their foundation towards the development of a more comprehensive system of suicide prevention.

**Core Principle 5. Broaden the spectrum of partners involved in a comprehensive system of suicide prevention.**

To align with the call to action that "Every Californian Is Part of the Solution," it is critical that long-term partnerships be developed with a broad range of partners that transcend the traditional mental health system. These partnerships may include the business community, ethnic and cultural community-based organizations, senior centers and aging services, the spiritual and faith communities, private foundations, schools and institutions of higher education, health and human service organizations, criminal and juvenile justice entities, and military partners, such as the Veterans Administration and the National Guard.

**Core Principle 6. Employ a life span approach to suicide prevention.**

Suicide prevention and intervention strategies should be targeted to Californians of all ages from children and youth, to adults, and older adults. It seeks to prevent crises from emerging as well as to provide prevention and early interventions to address problems long before they become acute.
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## Strategic Direction 1: Create a System of Suicide Prevention

Increase collaboration among state and local agencies, private organizations, and communities by coordinating and improving suicide prevention activities and services throughout the state, from health and mental health promotion and prevention through crisis intervention.

### Recommended Actions at the State Level

1.1 Establish an Office of Suicide Prevention to provide coordination and collaboration across the state and serve as an online clearinghouse of information about suicide data and related research findings, best practices, and community planning.

1.2 Engage a coalition of public partners to integrate, coordinate, enhance, and improve policies and practices that prevent suicide. These partners should include:

- Department of Aging
- Department of Alcohol and Drug Programs
- Department of Corrections and Rehabilitation
- Department of Education
- Department of Health Care Services
- Department of Managed Health Care
- Department of Mental Health
- Department of Public Health
- Department of Social Services
- Department of Veterans' Affairs
- Managed Risk Medical Insurance Board
- National Guard

1.3 Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide. The public and private partnerships should include:

- Community-based and ethnic-based organizations
- Community leaders
- Client, family, youth, and peer support advocacy groups
- Employers
- Health and mental health providers
- Insurance industry
- Local educational agencies and institutions of higher education
- Spiritual and faith-based organizations

1.4 Convene and facilitate topic-specific working groups that will address specific populations and issues, and develop, adapt, and disseminate resources and other materials that address the topic.

1.5 Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level, and enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.

1.6 Create a statewide consortium of suicide prevention hotlines. Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as Web-based sites.

1.7 Identify and implement needed improvements in confidentiality laws and practices to promote safety, health, wellness, and recovery.

**Recommended Actions at the Local Level**

1.8 In each county, appoint a liaison to the state Office of Suicide Prevention, and build upon an existing body or convene a new suicide prevention advisory council to collectively address local suicide prevention issues. Membership should reflect a broad range of local stakeholders with expertise and experience with diverse at-risk groups, including:

- Local government and nonprofit agencies, such as mental health, public health, law enforcement, education, and Area Agencies on Aging
- Coroners and medical examiners
- Tribal representatives
- Survivors of suicide attempts and family members
- Mental health clients

1.9 Develop a local suicide prevention action plan with the input of a diverse, representative group of stakeholders, including the entity designated as the local suicide prevention advisory council. The plan should:

- Identify measurable goals, objectives, and expected outcomes toward creating a comprehensive system of suicide prevention that includes health and mental health promotion through crisis interventions.
- Establish clear protocols for communication, including sharing confidential information, among systems and providers.
- Identify target population groups and strategies or an inclusive process for doing so.
- Create and monitor an effective crisis response system.

- Identify opportunities and embed and expand quality suicide prevention activities in local programs across systems.
- Provide for technical assistance to peer support programs, such as peer-run crisis respite centers and peer warm lines.
- Coordinate with the state Office of Suicide Prevention.
- Provide for periodic review of the county's progress and updates to the plan.
- Identify mechanisms to report on suicide prevention activities in existing county reporting structures, such as those for Mental Health Services Act components and county cultural competence reports.

1.10 Enhance links between systems and programs to better address gaps in services and identify resources to support local solutions to reducing suicide.

1.11 Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders, and hotlines. Establish formal partnerships that foster communication and coordinated service delivery among providers from different systems.

1.12 Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace, and the criminal and juvenile justice systems.

1.13 Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.

1.14 Ensure that the county has at least one accredited suicide prevention hotline call center or that the county has a formal partnership with an accredited call center.

1.15 For counties with an established, accredited suicide prevention hotline call center, work with the Office of Suicide Prevention to explore opportunities to provide training and consultation to other counties to develop their suicide prevention hotline capacity.

## Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide

Develop and implement service and training guidelines to promote effective and consistent suicide prevention, early identification, referral, intervention, and follow-up care across all service providers.

### Recommended Actions at the State Level

2.1 Convene expert workgroups to recommend, develop, disseminate, broadly promote, and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.

At a minimum, occupations selected for guidelines and curricula development and training should include:

- Primary care providers, including physicians and mid-level practitioners
- First responders, including police officers and sheriffs, emergency department staff and emergency medical technicians
- Licensed mental health and substance abuse treatment professionals and staff in outpatient and community-based settings as well as psychiatric facilities
- Social workers and other staff in older adult programs, in-home support services, adult and child protective services, and foster care
- Adult and juvenile system correction officers and probation and parole officers
- Administrators and faculty in elementary, middle, and high schools and in colleges and universities

Service and training guidelines should include direction and recommendations for the following:

- Promoting health, mental health, and prevention principles
- Addressing barriers related to mental health stigma and discrimination
- Increasing understanding of protective and risk factors, including the role of age, culture, race, sex/gender, and ethnicity in suicide prevention
- Improving suicide risk assessment and treatment
- Establishing specific actions for follow-up care after a suicide attempt and/or discharge from an emergency room, urgent care center, hospital, or at the end of a visit with a physician or health care staff
- Reviewing guidelines in health insurance plans to ensure effective response and services to assess and address suicide risk or suicidal behavior
- Implementing promising practices for law enforcement, such as crisis intervention teams

- Considering how to promote incentives for community organizations to provide suicide prevention training and to employ trained gatekeepers

2.2 Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing, graduate and professional program requirements, and continuing education programs.

2.3 Following implementation of 2.1 and 2.2, develop and implement a process for determining within five years which occupations are to be targeted for required training and how the requirements will be implemented.

**Recommended Actions at the Local Level**

2.4 Establish annual targets for suicide prevention training that identify the number of individuals and occupations that will receive training, and the models, including peer support, which will be used for training. Using an inclusive process for input, develop and implement training plans that meet these targets.

2.5 Increase the priority of suicide prevention training through outreach and by disseminating, tailoring, and enhancing state training guidelines as necessary to meet local needs.

## Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide

Raise awareness that suicide is preventable and create an environment that supports suicide prevention and help-seeking behaviors.

### Recommended Actions at the State Level

3.1 Launch and sustain a suicide prevention education campaign with messages that have been tested to be effective for diverse communities and that address warning signs, suicide risk and protective factors, and how to get help.

3.2 Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.

3.3 Engage the news media and the entertainment industry to educate them on standards and guidelines to promote balanced and informed portrayals of suicide, mental illness, and mental health services that support suicide prevention efforts.

3.4 Promote information and resources about strategies that reduce access to lethal means, such as gun safety education and increasing compliance with existing gun safety laws, safe medication storage, and physical and non-physical deterrent systems on bridges or other high structures.

3.5 Disseminate and promote models for suicide prevention education for community gatekeepers.

### Recommended Actions at the Local Level

3.6 Build grassroots outreach and engagement efforts to coordinate with and tailor the statewide suicide prevention education campaign and activities to best meet community needs.

3.7 Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.

3.8 Educate family members, caregivers, and friends of those who have attempted suicide, individuals who have attempted suicide, and community helpers to recognize, appropriately respond to, and refer people demonstrating acute risk factors.

3.9 Promote and provide suicide prevention education for community gatekeepers.

3.10 Develop and disseminate directory information on local suicide prevention and intervention services that includes information about how and where to access services and how to deal with common roadblocks.

3.11 Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.

## Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability

Improve data collection, surveillance, and program evaluation and launch a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations.

**Recommended Actions at the State Level**:

4.1 Develop a California surveillance and research agenda on suicide, suicide attempts, and suicide prevention to support data-driven policies and evidence-based programs.

4.2 Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups.

4.3 Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods, and provide training and technical assistance on program evaluation to the counties and local partners. Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities.

4.4 Coordinate with the Office of Suicide Prevention and county suicide prevention liaisons to make data and reports more accessible to, and in more user-friendly formats for, the public at large and policy makers at all levels to improve understanding of suicide and suicide attempts and to enhance prevention efforts for all population groups.

**Recommended Actions at the Local Level**:

4.5 Increase local capacity for data collection, reporting, surveillance, and dissemination to inform prevention and early intervention program development and training.

4.6 Build local capacity to evaluate suicide prevention programs and use the results to make program improvements, including community-based participatory research methods.

4.7 Establish or enhance capacity for a clinical and forensic review of suicide deaths in each county. The suicide death review process should include reporting de-identified data and findings to the State Office of Suicide Prevention and the local suicide prevention advisory council at minimum. The advisory

council could use the reports to inform local policy action recommendations. Members of the case review teams should include representatives of the Office of the Coroner/Medical Examiner and as appropriate other officials with legal access to confidential information.

4.8 Work with coroners and medical examiners to determine how to enhance reporting systems to improve the consistency and accuracy of data about suicide deaths.

# Part 4: Next Steps

The *California Strategic Plan on Suicide Prevention* has identified four major strategic directions and numerous recommended actions to reduce the number of suicide deaths and the incidence of suicidal behaviors in California. The plan calls for a substantial coordinated effort by multiple partners to identify and successfully achieve the necessary program, policy, and system improvements. Many of the recommendations require a long-term effort; others can be implemented immediately. The purpose of this section is to outline initial steps that should be taken to implement the recommendations in this plan.

The Suicide Prevention Plan Advisory Committee recognized that to succeed in both the short and long term, it is essential during the first phase of implementation to establish a solid foundation upon which to build. Further, the Advisory Committee acknowledged the need to be deliberate and sequential in implementing the recommendations (e.g., the need to enhance the capacity of the workforce before launching a major campaign that would increase the demand for services). Lastly, the Advisory Committee implored that the funding to support the ongoing services be at a sufficient and sustained level.

Success will be achieved through a collective and well-integrated effort; it cannot be solely dependent upon one funding source nor can the responsibility be shifted to any one entity. The theme, "Every Californian Is Part of the Solution," must ring true throughout the implementation of the strategic plan if suicidal behaviors are to be decreased and lives are to be saved. As a result, the implementation of the recommended actions, and the next steps will be the responsibility of an array of state, local, public, and private partners.

The Office of Suicide Prevention will serve as a coordination point for addressing many of the recommended actions in this plan. Leadership and support from other public agencies and private organizations must also play a paramount role. Thus, in conjunction with a number of key partners, the Office of Suicide Prevention will develop a detailed work plan to initiate its operation.

The DMH and the MHS Oversight and Accountability Commission (OAC), with support from the California Mental Health Directors Association (CMHDA), have recommended that counties direct approximately $14 million in MHSA funds each year for four years to support a statewide suicide prevention effort. A portion of the funding has been earmarked for Student Mental Health Initiative[13] funding for K-12, community colleges, and universities.

[13] The Student Mental Health Initiative is aimed to strengthen mental health for students in both K-12 and higher education through training, mental health education, peer support, violence

To launch this concerted effort to prevent suicide and suicidal behavior in California, the following activities should be considered for the initial five-year implementation phase that will provide a foundation for future work.

**Strategic Direction 1: Create a System of Suicide Prevention**

***State Level***

1.A Staff the Office of Suicide Prevention established within the California Department of Mental Health on February 6, 2008.

1.B Develop and issue an action plan that includes an assessment of the current level of activity and detection of major gaps, and identifies objectives toward implementing the initial activities described in this "Next Steps" section.

1.C Establish a technical assistance infrastructure of regional working groups/learning collaboratives, consultation, training, and other support methods, and a resource center to support local suicide prevention systems and efforts.

1.D Establish a state wide coalition of state-level organizations and public and private partners to better address the integration of effective suicide prevention policies, practices, and programs into existing service systems. The initial coalition will include the state agencies identified in Recommended Action 1.2 and be expanded to include the public and private partners identified in Recommended Action 1.3.

1.E Assess the current status of coverage and accreditation for suicide prevention hotlines in California. Beginning with call centers that are members of the National Lifeline, build a consortium of accredited suicide prevention hotlines statewide to expand access to standardized services throughout the state and to ensure full multilingual, cultural, and age-specific crisis coverage for all Californians.

1.F Provide technical support to expand functions for accredited suicide prevention hotline centers, such as training centers for various occupations and professions, including peer support providers and after-care service providers.

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prevention and suicide prevention activities in local education agencies and higher education campuses.

1.G Enhance the database for monitoring, tracking, evaluating, and reporting suicide prevention hotline calls in California. At minimum, collect information about calls and outcomes by age, sex, county location, and language.

1.H Provide technical assistance to expand or link accredited hotlines to additional venues and formats, including the Internet, 211 lines[14], Web-based self-help services, and other age-appropriate means to improve access to information on local suicide prevention and early intervention services.

1.I Provide technical support to counties to conduct a comprehensive assessment of suicide prevention services.

1.J Link and provide support to county-level advisory councils dedicated to developing the local coordinated suicide prevention system. Establish and maintain a collaborative relationship among the state and county liaisons.

***Local Level***

1.K Appoint a liaison to the state Office of Suicide Prevention in each county.

1.L Convene or build upon an existing entity to establish a county suicide prevention advisory council that is dedicated to developing the local coordinated suicide prevention system.

1.M Design and implement a comprehensive assessment of the existing county suicide prevention services and supports and the detection of major gaps that will inform the development of the local suicide prevention action plan, from health and mental health promotion through crisis intervention and after care.

1.N Develop a local suicide prevention action plan through an inclusive community process that includes review of the comprehensive assessment, identification of short-term and long-term objectives, establishment of milestones, and completion of a work plan. Establish the baseline of the targeted policy, program, and system improvements.

1.O Assess capacity of local or, where appropriate, regional accredited suicide prevention hotline(s) and take steps needed to achieve accreditation or

[14] 211 lines provide information about community services and information related to health and human services.

build the capacity (e.g., as training centers or after-care service providers; expand or link to web-based formats) of already accredited hotlines.

## Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide

### *State Level*

2.A Assess the current criteria and standards for service and training guidelines that address suicide prevention, early intervention, treatment, and suicide attempt follow-up care for California's diverse population. Begin with a review of the various occupations and professions identified in this plan to determine the first cohort of training programs to be assessed and enhanced. Identify opportunities for training program enhancements and work cooperatively with appropriate agencies to implement needed improvements.

2.B Convene expert work groups to recommend, develop, and broadly promote standard service and training guidelines and curricula for targeted service providers, including peer support providers, in California. Review licensing and credentialing processes to assess viability of new training requirements.

2.C Coordinate and review surveys on local training needs. Include in the Office of Suicide Prevention's action plan methods for supporting counties in addressing and providing the necessary training, utilizing distance-learning modalities, online services, and other effective methods. Secure resources and partnerships to expand available support.

2.D Deliver train-the-trainer sessions for targeted service providers.

### *Local Level*

2.E Review local MHSA Workforce Education and Training component assessments to identify elements relevant to suicide prevention efforts. To supplement information, survey suicide prevention training programs and needs and assess gaps. In conjunction with the state efforts, set local training targets for selected occupations, develop a plan with responsible parties to meet those targets and a process to measure progress.

2.F Disseminate and promote service standards and training guidelines. Design and implement an inclusive community process to adapt guidelines to better serve local needs as necessary.

## Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide

### *State Level*

3.A In conjunction with any existing social marketing efforts, such as stigma and discrimination reduction activities, develop and implement an age-appropriate, multi-language education campaign and messages specifically designed and pilot-tested to positively influence attitudes about the preventability of suicide, to increase appropriate help-seeking behaviors, and to reduce suicidal behaviors.

3.B Obtain the necessary social marketing consultation to design, test, and promote the suicide prevention messages in ways that will benefit target populations at risk for suicide. Develop, test, and produce accompanying outreach and educational materials.

3.C Support local efforts to engage and educate the media by disseminating selected resources from national and other suicide prevention organizations.

3.D Identify a strategy for reducing access to lethal means in California.

3.E Identify and disseminate models that counties can use to implement suicide prevention gatekeeper education.

3.F Conduct regional training to build local capacity for peer support programs.

3.G Design, produce, and maintain a web page for the Office of Suicide Prevention that provides links to the many sources of reliable information. Identify and develop additional new information needed to appropriately address the needs of all Californians.

### *Local Level*

3.H Coordinate local outreach, awareness, and education activities with other social marketing campaign efforts as a means to expand suicide prevention messages and information in multiple languages.

3.I Design and implement a strategy to better engage and educate the local media on the importance of appropriate and responsible reporting of suicide deaths and suicide prevention information.

3.J Design a community education plan that may include:

- Developing a community calendar of events and activities promoting suicide prevention awareness and education
- Identifying opportunities to integrate suicide prevention information into ongoing services in education, primary care, older adult, first responder, faith community, and other systems
- Localizing national and state suicide prevention events

3.K Reach out to community gatekeepers, including staff and volunteers providing home-based services, to increase their awareness and participation in suicide prevention efforts.

3.L Develop and widely disseminate a directory of local suicide prevention services and supports in multiple formats. Design a process to ensure that the directory is kept up-to-date.

3.M Foster the development of peer support programs, including support groups and networks.

**Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability**

***State Level***

4.A Working collaboratively with other local, state, and national entities develop a California-specific research agenda, including surveillance and evaluation, on suicide attempts and deaths and suicide prevention to support more effective policies and programs. Design a process to identify priority activities from a comprehensive review of multiple data sources and an inclusive decision-making process.

4.B Work to improve the collection and reporting of data as well as the systems for surveillance for a better understanding of the suicide trends and rates, and the impact of protective and risk factors among California's diverse population groups that can lead to more appropriate policies and programs. Target research activities in key areas, such as policies and programs appropriate for specific ethnic, cultural, and age groups, that are gender-specific, that address trauma and other factors, and that have effective application in multiple settings.

4.C Develop an evaluation component to track and monitor the statewide effort, including a system for monitoring and tracking national, state, and local policy changes and system improvements leading to a reduction in suicidal behaviors and suicide deaths in California.

4.D Develop and disseminate data reports on special topics and specific target populations by age, race, ethnicity, sex, gender, and other factors to enhance programs and service delivery.

***Local Level***

4.E Assess local data sources and reporting processes pertinent for suicide prevention and develop and implement a strategy to enhance data collection across systems.

4.F Coordinate with the state Office of Suicide Prevention to build local capacity for program evaluation, including community participatory research methods.

4.G Complete an inventory of existing death review teams serving the county. In coordination with the local suicide prevention advisory council, build the capacity for conducting a suicide death review process in each county and provide for regular reporting on suicide deaths to the suicide prevention advisory council.

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